NORTH CAROLINA HEALTH PLANNING COMMISSION

FINAL REPORT

December 21, 1994

North Carolina Health Planning Commission
2108 Umstead Drive, Post Office Box 29526, Raleigh, N. C. 27626-0526
Phone 919/715-4740 Fax 919/715-4759

James B. Hunt Jr., Governor
Chairman

James G. Jones, M. D
Executive Director

Members of the 1995 General Assembly
State Legislative Building
16 West Jones Street
Raleigh, NC 27601

Dear Legislators:

The North Carolina Health Planning Commission was established by enactment of Chapter 529 of the 1993 Session, HB 729, the Jeralds-Ezzell-Fletcher Health Care Reform Act. The law requires that the Commission report to the 1995 General Assembly with a plan for health reform for North Carolina.

With this letter we are conveying the report of the NC Health Planning Commission outlining the work of the commission and our findings about the numbers of uninsured and underinsured, rising health care costs, access to health care in all parts of North Carolina, and the current focus of the health system on illness rather than prevention. We have also looked at the impact of health care on the budgets of individuals, families, small and large businesses, and local and state governments.

This document highlights the work conducted over a period of months by both our 16-member Commission and the 17 Advisory Committees and Subcommittees we appointed. These were composed of more than 300 citizens from all parts of the state representing business, industry, all aspects of the health professions, insurance, health plans, consumer groups, local and state governments, and others.

We asked these groups each to take a separate aspect of the complex issue of health care and to give us their best thoughts. These committees held more than 80 meetings in more than 30 cities. They heard from more than 300 citizens in a variety of public forums. Using their reports and the fact-finding of the Commission itself, we have designed a set of recommendations which will be presented to you under separate cover.

These two documents comprise the report to the General Assembly of the NC Health Planning Commission. As elected leaders of the Commission we submit these to the 1995 Session of the General Assembly for your consideration.

Sincerely,

Chairman
James B. Hunt Jr.
Governor

Co-Vice Chairman
Daniel T. Blue, Jr.
Speaker of the House

Co-Vice Chairman
Marc Basnight
President Pro-Tempore

TABLE OF CONTENTS

I. INTRODUCTION

The North Carolina Health Planning Commission was established through enactment of Chapter 529 of the 1993 Session, HB 729, the Jeralds-Ezzell-Fletcher Health Care Reform Act of 1993. (A copy of the authorizing legislation is listed in Appendix A). The 16-member commission is chaired by Governor James B. Hunt, Jr. with Speaker Daniel T. Blue, Jr. of the House of Representatives and President *Pro Tempore* Marc Basnight of the Senate serving as Co-Vice Chairs. In addition, Lieutenant Governor Dennis A. Wicker serves as a member of the Commission, along with five members of the House of Representatives: Representative W. W. Dickson, Representative Karen E. Gottovi, Representative Josephus L. Mavretic, Representative Richard H. Moore, Representative Thomas E. Wright, and five members of the Senate: Senator George B. Daniel, Senator James S. Forrester, Senator Ted Kaplan, Senator Beverly M. Perdue, Senator A. P. Sands, III. The Secretaries of the Departments of Human Resources, C. Robin Britt, Sr., and Environment Health and Natural Resources, Jonathan B. Howes, serve as *ex-officio* members. The Commission is charged with developing a universal health care program to provide all North Carolina residents access to quality health care that is comprehensive and affordable.

II. COMMISSION PROCEEDINGS

A. Work of the Commission

The Commission met on 14 occasions between October 1993 and December 31. 1994. (A copy of the minutes from the Commission meetings is listed in Appendix B). At the December 1993 meeting, the Commission voted to offer the position of Executive Director to James G. Jones, M.D., Chair of the Dept. of Family Medicine at East Carolina University School of Medicine. Dr. Jones began full time employment with the Commission in February 1994. The Commission was fully staffed by May (and is staffed with a deputy director, four policy analysts, a public information officer and support staff). It also had the support of three consultants from the Duke Center for Health Policy Research and Education, Cecil G. Sheps Center for Health Services Research, and Blue Cross Blue Shield of North Carolina. (See Appendix C.) In addition, the staff worked closely with other state agencies involved in the delivery of health services, including the Department of Insurance, the Division of Medical Assistance, the Office of Rural Health and Resource Development, the Division of Aging, and the Division of Facility Services with the N.C. Department of Human Resources, the State Health Director, Division of Maternal and Child Health, Division of Adult Health Services, State Center for Health and Environmental Statistics with the N.C. Department of Environment, Health and Natural Resources, the N.C. Foundation for Alternative Health Programs, the Governor's Advocacy Council for Persons with Disabilities in the Department of Administration, and

the N.C. Teachers and State Employees Comprehensive Major Medical Health Plan. The Commission, through competitive bid, contracted with Coopers & Lybrand for actuarial services and Lewin-VHI for financial modeling services. Both of these firms are nationally recognized consulting firms with expertise in health care issues.

B. Advisory Committees

The Commission was directed to "appoint such advisory, technical, and professional panels as it deemed necessary to advise it on the performance and administration of its functions. Each panel shall consist of experts drawn from the health professions, health educational institutions, provider of services, insurers, and other sources, including consumers. At least three panels shall be established to advise, consult with, and make recommendations to the Commission on the development, maintenance, funding, evaluation, and priorities of community health services." G.S. 143-612(e).

To ensure adequate input from experts around the state and the public, the Commission created thirteen advisory committees to review and make recommendations about different aspects of the state's health system: Primary Care; Rural and Urban Medically Underserved Areas; Benefits (with four subcommittees on preventive services, primary acute and chronic care services, mental health and substance abuse services, and long term care services); Health Promotion, Disease Prevention and the Role of Public Health; Community Health Districts; Special Populations; Delivery Systems; Cost Containment; Data Collection and Information Systems; Financing; Eligibility and Enrollment; and Insurance Reform. (See list of Advisory Committee Members, Appendix D) These committees included more than 300 citizens from across the state, including representatives of business, academia, health care providers, insurance companies and health maintenance organizations, consumers, and others. Each Committee held 4-7 meetings, with opportunities for public input at each meeting after the initial organizational meeting. In addition, each committee held one evening three-hour public hearing.

The Advisory Committees of the Health Planning Commission began reporting to the Commission in September 1994. (A summary of their reports is included in Appendix E.)

III. PRINCIPLES

Based on discussions that transpired over three months, the Commission adopted a set of principles on August 23, 1994, to guide their health reform efforts and those of the Advisory Committees. These principles are as follows:

1. *Universal Coverage* - All North Carolina residents should have continuous, portable health coverage and reasonable access to essential health services, regardless of their age, sex, race, disability, geographic, economic, employment or health status.

2. *Cost Containment* - The health system should create incentives to control costs and eliminate waste with the goal of limiting health spending more closely to the rate of real economic growth.

3. *Comprehensive Benefits Package* - The health system should ensure that individuals have coverage for comprehensive health services that meet a person's essential health needs.

4. *Choice* - The health system should facilitate choice of providers and plans within the confines of overall affordability.

5. *High Quality Coordinated Services* - The health system should ensure the delivery of high quality, coordinated health services.

6. *Emphasis on Improving Health Status* - The goal of any future health system should be on improved health status of individuals, with an emphasis on primary care, health promotion, disease prevention and health education.

7. *Access to Services* - All North Carolina residents, including individuals living in rural and urban medically underserved areas, should have reasonable access to all covered health services.

8. *Affordability* - Health care premiums, and out-of-pocket payments should be affordable for individuals, families and businesses.

9. *Personal Responsibility* - The health system should be built upon the principle that individuals share responsibility for their health status, should be encouraged to pursue healthy behaviors, and should be taught to use the health system appropriately.

10. *Simplicity* - The health system should be understandable, simple to use, and should minimize administrative burdens for providers, consumers, and payers.

11. *Community Involvement* - Communities should be involved in developing local solutions to health problems, including the identification of critical health needs, as a way of guiding the allocation of health resources.

12. *Licensed or Certified Health Professionals* - The new health system should recognize the role of all appropriate categories of licensed or certified health professionals in improving the health status of the citizenry of North Carolina.

13. *Malpractice Liability Reform* - Health care reform should include modification of the current medical liability system to encourage an appropriate level of utilization of medical services and to control excess costs. The modified system should preserve incentives to improve the standard of care and should enhance the availability of services.

IV. NEED FOR HEALTH CARE REFORM

There are numerous reasons underlying the need for health care reform, including: the need to encourage a shift in the delivery of health services away from the curative model towards one of prevention and wellness, the growing numbers of uninsured, rising health

care costs and affordability of coverage, cost shifting, and the uneven ability to access necessary services.

A. *Our current health system focuses almost all of its resources on curing illness, rather than preventing illness and keeping people healthy.*

National studies suggest that only 10 percent of the deaths in this country are related to the medical care a person receives or does not receive, while 20 percent are due to environmental factors, 20 percent are due to genetics, and 50 percent are due to lifestyle choices.[1] Despite studies which suggest that so much of health status is due to lifestyle choices and other preventable illnesses,[2] traditional insurance plans place little emphasis on preventive health services. For example, only 43 percent of traditional fee-for-service indemnity plans in 1993 covered adult physicals, and only 56 percent provided coverage of well-child care.[3] Of the approximately $21 billion dollars spent on health care in North Carolina in 1994, only about one percent was spent on population-based public health services intended to improve the health status of the people in the community.

In North Carolina heart disease, cancer, cerebrovascular disease, unintentional injuries, chronic lung disease, pneumonia and influenza, diabetes, suicide, chronic liver disease/cirrhosis, and HIV infection are among the leading causes of death. Many, if not most, of these diseases are preventable. Interventions which can prevent disease include immunizations and chemoprophylaxis (use of chemical agents to prevent disease or other unwanted health conditions), screening tests, health education, behavioral strategies and environmental strategies. Among children, the two most effective preventive measures are early and consistent prenatal care and immunizations. Some experts believe that up to half of all health spending can be attributed to our lifestyles.[4]

---

[1] US Department of Health and Human Services. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, 1979..

[2] According to the *Source Book of Health Insurance Data, 1993* from the Health Insurance Association of America the cost per patient of preventable medical conditions is as follows: heart disease (7 million affected, 500,000 deaths/year, 284,000 bypass procedures a year) $30,000 (bypass surgery); cancer (1 million new cases/year, 510,000 deaths/year) $29,000 (lung cancer treatment); stroke (600,000 strokes/year, 150,000 deaths/year) $22,000; injuries (2.3 million hospitalized /year, 142,500 deaths/year. 177,000 persons with spinal cord injuries) $570,000 (lifetime/quadriplegia); HIV infection (1-1.5 million infected, 147,525 AIDS cases as of January, 1990) $75,000 lifetime treatment; Alcoholism (18.5 million persons abuse alcohol, 105,000 alcohol deaths/year) $250,000/liver transplant; drug abuse (regular users 1.3 million persons use cocaine, 900,000 use IV drugs, 500,000-heroin, drug exposed babies-375,000) $63,000 in five years; low birth-weight baby (260,000 LBWB born/year, 23,000 deaths) $10,000/intensive care.

[3] *Medical Benefits, Trends in Health Insurance*: "HMOs Experience Lower Rates of Increase Than Other Plans", Table 1 (Prevalence of employees in health plans offering specified covered benefits. 1988 to 1993). Volume 11, Number 6.

[4] Health Access Forum. *Universal Access at an Affordable cost: Ensuring Health Care Services for all North Carolinians*, North Carolina Institute of Medicine, Durham, NC, January, 1993.

B. Almost one-third of the state's population is either uninsured or underinsured to meet their health needs.

In North Carolina, 920,000 of our state's citizens are uninsured on any given day.[5] Over the course of the year, almost 1.4 million people will experience some period of time in which they are uninsured.[6] This figure is likely to grow in the future.[7]

The fastest growing group of uninsured North Carolinians is the working middle class. While in 1985 less than 20 percent of those without health insurance were working middle class, by 1993, almost 40 percent were working middle class.[8] Of those who are uninsured, 75 percent had jobs or are members of families headed by a wage earner. Some workers are excluded from coverage due to pre-existing conditions. Others lose coverage if they lose or switch jobs or if their employer decides that health insurance is no longer an affordable option.[9] Under these conditions, nearly everyone is vulnerable to potential loss of health care benefits.

The problem of inadequate insurance coverage is not limited to the uninsured. There are almost 900,000 additional people in this state who have some coverage, but it is inadequate to meet their total comprehensive health needs.[10] These individuals fall into five general categories: 1) those who have health insurance, but are subject to pre-existing condition exclusions; 2) those who have limited policies, which may cover hospitalizations but not outpatient care, or which cover only treatment for certain dread diseases (such as cancer policies); 3) those who have Medicare as their sole source of coverage[11]; 4) those who are subject to very large deductibles ($2,000 or $5,000 deductibles, generally referred to as catastrophic policies); or 5) those who have reached

---

[5] Based on analysis of North Carolina sample from March, 1993 *Current Population Survey*, conducted by Thomas Ricketts, Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill.

[6] Based on an extrapolation of annual and point-in-time estimates of the uninsured derived from the 1987 *National Medical Expenditure Survey* data to point-in-time estimates of North Carolina uninsured. Extrapolation done by Chris Conover, Duke University Center for Health Policy Research and Education.

[7] Families USA Foundation, *Two Million Americans Lose Health Insurance Each Month*, September 15, 1993. Estimates developed by Lewin-VHI based on the 1990 Survey of Income and Program Participation, the 1987 National Medical Expenditure Survey and four years of pooled Current Population Survey data (March supplement). In North Carolina, the report estimates that 64,000 people lose their health insurance each month.

[8] Presentation by Christopher Conover to the N.C. Health Planning Commission, December 17, 1993.

[9] Families USA Foundation, *How Americans Lose Health Insurance*, April, 1994, Lewin-VHI based on the 1990 Survey of Income and Program Participation, the 1987 National Medical Expenditures Survey, four years of pooled March Current Population Survey data, Bureau of the Census, *State Population Estimates by Age and Sex: 1980-1992*, P25-1106, and Bureau of the Census, *Population Projections of the United States, by Age, Sex, Race and Hispanic Origin: 1993 to 2050*, P25-1104.

[10] Presentation by Christopher Conover to the N.C. Health Planning Commission, July 20,1994.

[11] 65.3 percent of the elderly in North Carolina have private coverage, such as Medicare supplements. AARP, *Reforming the Health Care System: State Profiles 1994*, August 1994. Data from March 1993 Current Population Survey, as reported by Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1993 Current Population Survey*, Issue Brief Number 145, Special Report 20.

annual or lifetime maximums under the plan or for specific services covered under the plans (such as cancer, cardiovascular disease, or mental health coverage). These individuals are counted among the insured; but lack coverage for the very conditions that they most need help.

C. *Health care costs are still rising faster than families, businesses or government can absorb them.*

1. Total Health Care Spending in North Carolina

It is estimated that in 1994, North Carolina will spend $21 billion[12] on health care. This is approximately $3,000 for every man, woman and child in the state.[13] Of this, nearly 90 percent is for personal health services (such as hospital and physician care), 1.4 percent is for public health (such as health inspections and environmental health regulation), 2.8 percent for construction and research (excluding privately funded research such as that conducted by medical device manufacturers and pharmaceutical companies), and 6.0 percent for administration (which includes administration for public programs such as Medicaid and Medicare and insurance company administrative costs/profits). The latter figure does *not* include administrative costs in hospitals (one-third of hospital expenditures are related to administration) or physician/other professional offices (31.6 percent is for administration). If these are included, *total administrative costs amount to more than one quarter of all health spending in North Carolina.*[14] Put another way, administrative costs alone consume over $5 billion a year in this state.

On a per capita basis, North Carolina's spending is nearly 20 percent lower than the U.S. average. However, this difference varies by type of service: for prescription drugs, for example, North Carolina's spending is slightly above the U.S. average. Conversely, physician expenditures are one-fourth below the U.S. average. However, North Carolina cannot be complacent about its margin of advantage: for every service shown above, *North Carolina's margin of advantage is smaller today than in 1966.*[15] Overall, North Carolina

---

[12] Presentation by Christopher J. Conover, Duke University, to the North Carolina Health Planning Commission, August 23, 1994.

[13] $21 billion divided by 7 million people is $3,000 per person.

[14] Administrative costs for hospitals, physicians and other professional are derived from detailed administrative cost calculations developed by Lewin-VHI: the Lewin-VHI estimates of administrative costs as a percent of hospital and physician/other professional spending are applied to 1994 estimates of total health spending to obtain 22.8 percent of total spending, to which is added the 6 percent for administration costs previously discussed.

[15] 1994 estimates of per capita spending are reported in AARP (1994) and have been adjusted to account for North Carolina residents who receive care outside of the state and non-residents who receive care in North Carolina. Thus, the final figures represent average health spending by North Carolinians, regardless of where they received care. The 1966 figures are slightly different, since they are not residence-adjusted: they represent total health spending which occurred within the state's borders divided by total state residents. However, 1980 data for Medicare hospital charges suggest that only 5.7 percent of hospital care received by Medicare eligibles living in North Carolina was obtained out of state, while 5.3 percent of Medicare hospital spending within North Carolina's borders was obtained by Medicare eligibles living outside of North Carolina. (Levit, 1985). The net effect is that if North Carolina hospital spending were to

per capita health spending was 29 percent lower than the U.S. average in 1966, but today is 18 percent lower.

2. Trends in Health Care Spending

Health care costs in North Carolina increased at double digit rates from the mid-1980s until 1993.[16] These increases occurred in most categories of care, but particularly for hospital care, both inpatient and outpatient, and prescription drugs. The reasons for the increases are multiple and complex. They include general inflation, an aging population, tightening of reimbursement for Medicare and resulting cost shift, greater numbers of uninsured, growing supply of physicians and greater availability of expensive high-tech medicine. Perhaps the greatest driver of cost increases during this time period was the growing number of facilities offering new medical technology and the corresponding use of the new services. The decade of the '80's, and particularly the latter half of the decade, can be characterized as a medical arms race in the North Carolina health arena--and the target area for that expansion was medical equipment that is state-of-the-art in modern technology. This arms race was enabled by a change in the CON law in 1986 that raised the review ceiling for new equipment and services to $2 million.[17] Equipment and services that could be developed for less than that amount did not have to justify its need in the community.

Over the past two years, health care costs have moderated. There are several explanations for the slowing trend. Some argue that the threat of health care reform has changed the behavior of the marketplace and inserted a degree of cost-consciousness that did not exist

---

be adjusted for these largely offsetting effects, it would increase the estimate of hospital spending by 0.3 percent. A more recent calculation of the adjustment needed to account for all border crossing (not just hospital services) suggests that total health spending would be adjusted downward by 4 percent (PPRC, 1994). If such an adjustment were applied to the 1966 data, this would have the effect of widening the North Carolina margin of advantage for that year. Thus, unless border crossing has changed substantially since 1966, the conclusion that North Carolina's margin of advantage is shrinking is correct even though the data available to make such a comparison are not precisely apples-to-apples. Extrapolation done by Christopher Conover, Duke Center for Health Policy Research and Education.

[16] Estimates by Lewin/ICF show that total health spending in North Carolina rose from $4.7 billion in 1980 to $19.9 billion in 1993--or 10.7 percent a year. Families USA, *Skyrocketing Health Inflation*, 1980-1993-2000. Washington, D.C.: November 1993

[17] Several examples illustrate this arms race. From 1985 to 1993, the number of hospitals offering cardiac catherization grew from 13 to 58. The number of cardiac catherization units has more than quadrupled to the point that excess capacity exists in the State. Yet no price reduction has ensued. The average charge for a cardiac cath more than doubled during that time period. The story with open heart surgery units is similar. As the number of units has nearly doubled from 10 to 19, the price mounted steadily from under $30,000 to $55,000. There are several reasons why competition has not served to lower prices in the health care sector as it does in other areas of the economy. First, and foremost, the predominant fee-for-service reimbursement system encourages the purchase and use of more equipment and services. Providers are able to charge sufficient amounts to recover their costs on equipment and services that are not used to capacity. A second reason for the lack of price competition is that patients are seldom in a position to price shop when they need health care services. Testimony of Dr. Sandra Greene, Senior Director of Health Economics, Blue Cross Blue Shield of North Carolina, to the N.C. Health Planning Commission, August 23, 1994.

previously. One reason may be that providers realize there are limits to cost increases and have decided to hold the line on costs. If the threat of meaningful health reform is removed, the argument goes, then health care costs will increase its rapid escalation. [18]

Others argue that the explanation for the moderation in the rate of increase in health care costs is the expansion of managed care. [19] The evolution of managed care has been slower in North Carolina than in some other parts of the country, but it is beginning to spread and show some effectiveness.[20] There are two key components of managed care that are serving to slow health inflation: utilization management programs which assure that rendered care by qualified providers is appropriate for the given illness or set of symptoms, and pricing arrangements.[21]

A third theory is that the recent slowdown in health spending is more likely related to the economic slowdown around 1990 (and low inflation rate).[22] This implies that the recent upturn in the economy since 1990 is likely to produce an upsurge in health expenditure trends.

Despite the recent moderation in the escalation of health care costs, health care prices still rose at more than twice the rate of general inflation in 1993, and overall health care spending rose at more than four times the rate of general inflation. [23] Thus, regardless of

---

[18] When the Nixon administration debated health care reform in the first Nixon administration, a temporary slowdown in the cost increase cycle occurred. A slowdown occurred in the rate of hospital price increases in the late 1970's as the Carter administration debated hospital price controls. After the hospital cost containment legislation was defeated, the rate of price increase resumed its normal accelerating upward trend. Paul Starr, *The Social Transformation of American Medicine*, New York, Basic Books 1982. Pages 405-406.

[19] A recent study by Lewin-VHI showed that network based managed care saves money over the traditional managed indemnity programs (i.e., fee-for-service comprehensive medical plans), and that these are not one-time savings. *"New Evidence on Savings from Network Models of Managed Care,"* a Report submitted to the Healthcare Leadership Council, Lewin-VHI, May 5, 1994.

[20] Of the 63.5 percent of the non-elderly with employer based coverage in 1993, 26.0 percent were in traditional major medical fee-for-service plans, 27.2 percent were in Preferred Provider Organizations (PPOs), 7.5 percent were in HMOs, and 2.8 percent were in Point-of-Service plans. It is estimated that within 3 to 5 years, most coverage will be network based managed care (PPO, HMO or POS), with little traditional coverage in effect. Testimony of Sandra Greene, Dr.P.H., testimony to the Delivery Systems Advisory Committee, June 22, 1994.

[21] Traditional fee-for-service reimbursement rewards providers for doing more, whether it is needed and appropriate or not. Managed care pricing arrangements predominately use fee schedules with performance incentives, global pricing, DRGs, and capitation.

[22] J. Cookson and P. Reilly, *Modelling and Forecasting Health Care Consumption*, Milliman and Robertson, May 19, 1994. The report analyzed 30 years of health expenditure data and found that the recent slowdown in health spending is more likely related to the economic slowdown around 1990 rather than a reaction to health reform. For every one percent change in real personal income, national health spending rises by 0.88 percent three to five years later. The report also found that market penetration of HMOs accounted for very little of the slowdown in spending.

[23] Health care costs began to moderate in the last year. Studies showed that health care prices increased at only 5.5 percent in 1993, which was a considerable decline in the rate of medical price inflation over previous years. *News and Observer*, "Medical Costs Take Breather: Slowdown in Health Prices Mixed Blessing, Analysts Say," Dec. 22, 1993. However, even the recent decline in the rate of increase is still

the reason for the recent moderation in health care costs, the state still has reason for concern. Health care prices are rising more rapidly than the average income of a North Carolina family or business and faster than the growth in government revenues; making it increasingly difficult for families, businesses and government to continue to pay for health services.

3. Family Health Expenses

In North Carolina, *family payments* for health care (including out-of-pocket costs, Medicare payroll tax and premiums, and general taxes) increased from $1,533 in 1980, to $4,722 in 1993, an increase of 9.0 percent a year. However, average family incomes only increased 5.2 percent a year during that same period. If trends continue, family expenditures for health care costs are expected to reach $9,087 by the year 2000.[24]

Not only do escalating health care costs impact on the costs of health care services, they eat away at every family's standard of living. The average North Carolina family would have taken home more than $1,000 in 1992 alone in reduced health spending and higher wages, had health care costs stayed at the rate of inflation.[25]

4. Business Health Expenses

Similarly, health care costs are rising faster than business profits. In 1965, business health spending as a share of corporate after tax profits was 12.4 percent. In 1980 it was 41.2 percent. In 1991, the latest year for which figures are available, business health spending as a share of corporate after tax profits was 97.5 percent. [26] Businesses have responded to the rising health care costs by shifting more of the costs on to consumers, cutting back benefit packages, or dropping coverage altogether. A recent Health Insurance Association of America study showed that between 1989-1991, employers of all sizes were dropping coverage, although the largest drop in coverage was for employers with between 25 and 99 employees. In two years alone, approximately 12 percent of this sized employer dropped their insurance coverage for their employees.[27] In addition, recent changes in accounting standards have prompted nearly every employer to revisit retiree coverage.

---

twice the rate of growth in general inflation. The rate of growth in the Consumer Price Index in 1993 was 2.7 percent. U.S. Bureau of Labor Statistics. Further, while health care prices began to moderate, overall health care spending still rose at 12.1 percent, four times the rate of general inflation. Jerry Geisel, "Nation's Health Care Bill to Top One Trillion in 1994," *Business Insurance*, Jan. 3, 1994 citing Dept. of Commerce Report, U.S. Industrial Outlook: 1994.

[24] Families USA, *Skyrocketing Health Inflation, 1980-1993-2000: The Burden on Families and Businesses*. November 1993.

[25] SEIU, *Out of Control, Into Decline: The Devastating 12-Year Impact of Healthcare Costs on Workers Wages, Corporate Profits and Government Budgets*, Oct. 1992.

[26] Cathy A. Cowan and Patricia McDonnell, The Business, Household and Government: Health Spending, 1991, Health Care Financing Review, Spring, 1993, page 231.

[27] Cynthia Sullivan, Marianne Miller, Roger Feldman and Bryan Dowd, "Employer-Sponsored Health Insurance in 1991", *Health Affairs 11*, No. 4, Winter, 1992: 172-185.

5. Government Health Spending

a. State Spending

State government is the largest employer in the state, and is seen, by many, as a role model for employee benefits. Like other employers, government at the local, state, and federal level is also feeling the squeeze of health care cost escalation. At the state level, the two biggest health related costs are the state employees health plan and the state's share of Medicaid. The claims payment for the N.C. Comprehensive Major Medical Plan climbed from $228 million in FY 1985 to $508 million in FY 1994, an increase of 123 percent. During the same time period, General Fund tax and non-tax revenues increased 107 percent.[28] Meanwhile, the employee and family rate climbed from $125 in 1984-85 to $361 in 1993-94, a 189 percent increase.[29] The federal, state, and local budget expenditures for Medicaid provider payments rose from $634 million in FY 85 to $2.7 billion in FY 94 (an increase of more than 300 percent).[30] *Current spending on health programs amounts to approximately one-third of the entire state budget including federal receipts.*[31]

b. Local Government Health Spending

North Carolina's municipal governments formed a self insurance pool in July 1983 when the commercial carrier for the state's municipalities proposed a 55 percent increase in rates. From 1984 to 1995, the Municipal Insurance Trust of North Carolina's total increase was 144 percent.[32] During that same period of time, the Consumer Price Index increased by 42 percent.

Similarly, the N.C. Association of County Commissioners reported steady increases in their health related expenditures from FY 1988 to FY 1993. Local county expenditures for health related costs climbed from $362 million in 1987-88 to $612 million in 1992-93, a 69 percent increase.[33]

c. Federal Government Health Spending

At the federal level, health care costs continue to eat into every level of the budget. The United States currently spends about 14 percent of its GNP on health care. Experts predict that by the year 2000, we will be spending close to 20 percent of our GNP on

---

[28] *Overview of the NC State Budget*, Office of State Budget and Management, December 1993

[29] Presentation by Dave DeVries, Director of the State Employees Health Plan, to the NC Health Planning Commission, August 23, 1994.

[30] Presentation by Marvin Dorman, State Budget Director, to the N.C. Health Planning Commission, November 29, 1994.

[31] Ibid.

[32] Handout to NC Health Planning Commission for meeting of August, 23, 1994, prepared by the NC League of Municipalities, Municipal Insurance Trust of N.C.

[33] Handout to the NC Health Planning Commission for meeting of August 23, 1994, prepared by the NC Association of County Commissioners.

health care, and by the year 2030, we may be spending anywhere from 26-43 percent of our GNP on health care.[34] Over the last ten years, rising costs of health care have remained the uncontrolled cost driver on the national level which has made deficit control a virtual impossibility.

D. The High Costs of Health Insurance Makes Coverage Difficult for Many

Much of the uninsured problem relates to affordability of coverage. The cost of the premiums for even the *least expensive* plan recommended to the Commission would absorb more than one-fourth of family income for a family of four with a poverty level income.[35] Out-of-pocket costs, in the form of deductibles and copayments for this plan, would add at least another 20 percent to this amount, putting the total cost in excess of one-third of that family's income.

E. Rising health care costs and the growing numbers of uninsured are so intrinsically mixed that it is impossible to address rapidly rising health care costs without also addressing the numbers of uninsured.

As health care costs continue to escalate, more and more people are losing coverage. However, the costs of providing care to the uninsured do not disappear. The costs of this care are shifted onto the insured or paying patients ("cost shifting"), thus driving up costs to the insured even more. For example, Blue Cross Blue Shield estimates that 33 percent of hospital charges are due to cost shifting.[36] These higher costs in turn force more people to drop coverage.

F. The uninsured are less able to access primary and preventive care services, and consequently, are more likely to die prematurely.

Overall statistics show that the uninsured are generally sicker than those with insurance coverage, but they use 30-50 percent fewer services.[37] The uninsured, for example, are

---

[34] Extrapolation based on HCFA projections. Sally Burner, Daniel Waldo, David McKusick, "National Health Expenditures Through 2030", *Health Care Financing Review*, Fall 1992, Vol. 14, No. 1; Daniel Waldo, Sally Sonnefeld, Jeffrey Lemieux, David McKusick, "Health Spending Through 2030: Three Scenerios", *Health Affairs*, Winter 1991. Extrapolation done by Chris Conover, Duke University Center for Health Policy Research and Education, Dec. 1993.

[35] The Benefits Advisory Committee recommended three benefits plans to the Commission. The low cost plan, or the basic plan, would cost $350.44 per month in premium costs for a family. The 1994 federal poverty guidelines for a family of four is $14,800/year, or $1,233.33 per month. Thus, the premium costs of the basic plan, by themselves, would amount to 28.4% of the gross income of a family living in poverty, and would amount to 19% of a family living at 200% of the federal poverty guidelines ($22,000/year for a family of four).

[36] Presentation to the NC Health Planning Commission, August 23, 1994 by Dr. Sandra Greene, consultant to the Commission, of Blue Cross Blue Shield of N.C.

[37] The evidence summarizing the relative use rates of uninsured compared to insured individuals is contained in a Report by the Office of Technology Assessment, *Does Health Insurance Make a Difference?* September 1992.

twice as likely as those with insurance to lack a regular source of care.[38] In addition, the uninsured are less likely to obtain preventive screenings. As a result of their inability to pay for services, the uninsured tend to wait to seek medical care until they are in the midst of a medical emergency. A Washington D.C. study showed that if accidents and pregnancies are excluded, nearly 40 percent of all hospital use by the uninsured is medically preventable.[39] *In North Carolina, a recent study suggested that more than 164,000 hospital admissions could have been prevented by prompt access to primary care.*[40] In addition, a recent Journal of the American Medical Association article showed that after accounting for all other factors (including income and race), being uninsured increased the chances of early death by 25 percent.[41] *Extrapolating this data for North Carolina, every year that the state delays implementing a system of universal health insurance coverage, 800 North Carolinians die needlessly.*[42]

G. Almost one-fifth of North Carolinians have inadequate access to primary care providers, and the problem is likely to get worse in the foreseeable future.

There are 62 counties in North Carolina that have been designated health professional shortage areas--areas of the state that have too few primary care doctors to meet the health needs in the community. Thirty-three of the counties (all but one of them rural) have a county-wide shortage of health care providers, and 29 other counties (22 of them rural), have at least one township that is medically underserved. A total of 22 percent of the state's residents reside in these health professional shortage areas.[43] Although there have been improvements over the years in the number of primary care practitioners in rural and urban medically underserved areas, the distribution of health care providers in the state remains skewed towards the urban centers, where salaries are higher and hours better.

The difficulty in attracting and retaining primary care providers into medically underserved areas is likely to grow worse in the near future. If the North Carolina health system continues its recent acceleration towards managed care, the trends are clear. In 1994, there were 14 HMOs licensed in North Carolina, with an additional five license applications pending. Approximately 30 to 60 PPO's have requested applications.[44]

---

[38] Analysis of North Carolina Citizens Survey data for 1979-1984, as reported in Patricia M. Danzon and C. Johnston Conover, *Health Care for the Uninsured Poor of North Carolina.* Durham: Duke University Center for Health Policy Research and Education. August 1985.

[39] Billings, John, and Nina Teicholz. "Data Watch: Uninsured Patients in District of Columbia Hospitals," *Health Affairs* (December 1990): 158-165.

[40] Data from N.C. Medical Database Commission. Analysis completed by Tom Ricketts, Cecil G. Sheps Center for Health Services Research, using criteria set by the Institute of Medicine in: National Academy of Sciences, Institute of Medicine. *Access to Health Care in America.* Washington, DC: National Academy Press, 1993, pp. 219-221.

[41] Peter Franks, Carolyn Clancy, Martha Gold, "Health Insurance and Mortality: Evidence from a National Cohort," *Journal of the American Medical Association*, Aug. 11, 1993.

[42] Extrapolation done by Chris Conover, Duke Center for Health Policy Research and Education, based on the number of North Carolinians who die each year.

[43] Information provided by Mark Snuggs, N.C. Office of Rural Health and Resource Development.

[44] Information provided by NC Department of Insurance, Managed Care Division, 1994 figures.

Incoming HMOs will require primary care physicians and other providers to staff their expansions into the state. Typically these larger organizations have the financial resources to offer significantly higher salaries to attract physicians away from rural and underserved areas and into affluent urban areas. North Carolina has a total of 90 primary health care centers and federally-funded Community/Migrant Health Center sites that provide medical care in medically underserved areas. These medical practices depend on primary care physicians, nurse practitioners, physicians assistants, and certified nurse-midwives. If only one or two of these practitioners from many of these centers relocate to urban locations, the state's already fragile rural health system would be seriously weakened.

Further, the acceleration in the use of managed care plans has the potential of creating additional problems for rural hospitals. The push to slow the rate of health care cost escalation will inevitably lead to a significant decline in use of hospitals (both in admissions and length of stay). This trend may potentially force the closure of many small rural hospitals.

V. HISTORY OF PRIOR HEALTH REFORM EFFORTS

North Carolina is not new to the health reform arena. (See Chart on Prior Health Reform Efforts, Appendix F). The state has four strong medical schools, the leading Area Health Education Centers program in the nation, the first state Office of Rural Health, and strong medical research institutions affiliated with its medical schools. This progressive picture is the result of a conscious effort by the state to reverse a dismal picture of health and health care that emerged from World War II when North Carolina had the highest proportion of draftees and recruits rejected for military services due to medical conditions.

In 1944, Governor J. Melville Broughton started a program to strengthen the state's hospitals and enlarge its medical schools. This was combined with a grass roots campaign headed by band leader, Kay Kyser, to bring public attention to the need for better health care in the state. With the support of the General Assembly, the availability of money from the Duke Endowment, and new federal grants for hospitals, between 1947 and 1952 the state expanded the University of North Carolina School of Medicine to a four-year program, built a teaching hospital to serve the state, and expanded the number of hospital beds by 5,000.

The expansion of the University of North Carolina Medical School was matched by a new emphasis on public health and the rapid growth of the UNC School of Public Health. The private medical schools at the Bowman Gray School of Medicine and Duke University were closely involved in the development of coordinated programs to staff the hospitals and support the physician needs of the state. Innovators in the organization and planning of the health care services and training of new health professionals were attracted to North Carolina. They saw the state as a willing location for experiments in health care delivery and health care organization.

This climate fostered the development of the first physician assistant training program at Duke University Medical School, the development of one of the earliest nurse practitioner training programs at the University of North Carolina School of Nursing, the organization of the Office of Rural Health in 1973, and the organization of the statewide Area Health Education Centers Program in 1974. This period of innovation saw an active health planning community develop, initially around the Regional Medical Program, then the Comprehensive Health Planning Program culminating in the integration of health planning into the state government structure in 1975 after the passage of the federal Health Planning and Resource Development Act of 1974.

Cost containment has been an issue in the state since the late 1960s. North Carolina has remained as a Certificate of Need (CON) state although its health planning functions are much smaller. Regional health planning no longer exists. The Peer Standards Review Organization (PSRO) structure in the state was not effective and was curtailed. More recently, review of Medicare payments has been assumed by an independent Peer Review Organization, Medical Review of North Carolina.

North Carolina joined the Medicaid program early, and that program has been one vehicle for the support of health care services for the poor in the state. The Medicaid program has grown dramatically in North Carolina, from $14 million in 1970-71 to approximately $1 billion in state and local funds in 1994. Much of the effort to expand access to care in the state has been through the Medicaid program, which works closely with other systems including health departments, community health centers, university training programs, and rural health clinics to meet the health care needs of the indigent and categorically needy in the state.

The character of reform in North Carolina has been incremental and has depended upon a high degree of collaboration among the major providers and insurers in the state to keep the system from becoming too unbalanced. That ability has been outpaced by medical cost inflation and the growing numbers of uninsured, and the national trends toward specialization, dependence upon technology, and more integration of structures. In response to the growing problems, the General Assembly established the Indigent Health Care Legislative Study Commission which was directed to study the problems of the uninsured poor from 1985-1989. The Study Commission's recommendations which were ultimately adopted by the General Assembly included significant Medicaid expansion to cover poor children and pregnant women, as well as insurance reform legislation to ensure portability in the larger group market. However, the numbers of uninsured continued to rise, as did the costs of providing health care.

In 1991, in response to the continuing problems, the General Assembly created the Legislative Study Commission on Access to Health Insurance. This Commission recommended a managed competition model to ensure universal coverage by the year 1998. The Commission also recommended some interim recommendations, which were passed by the General Assembly, including: Medicaid expansion for children, elderly and disabled; a primary health care initiative, to attract more primary care providers to

medically underserved areas; strengthening the Certificate of Need laws; prohibiting provider self-referrals; and expanding the Caring Program for Children, a private-public partnership with Blue Cross Blue Shield, providing ambulatory care services to children in low and moderate income families. In 1991, the N.C. General Assembly also passed health care legislation making it easier for small groups to purchase insurance. At the same time, the N.C. Institute of Medicine established a blue ribbon panel, the Health Access Forum, chaired by Dr. William Friday. This group also recommended that the state provide universal coverage to all of its residents through a system of managed competition, similar to the proposal recommended by the N.C. Legislative Study Commission on Access to Health Insurance.

Despite North Carolina's past health care reform efforts, nearly a million of our citizens remain uninsured, North Carolinians rank at or near the bottom of almost every national health indicator, and health care costs are escalating faster than families, businesses or government can absorb them. The 1993 General Assembly recognized the need to bring together all the top political leadership in the state to address these problems systematically, and thus passed the Jeralds-Ezzell-Fletcher bill, Chapter 529 of the 1993 Session Laws, creating the North Carolina Health Planning Commission. In addition, the General Assembly enacted the Health Care Purchasing Alliance Act, G.S. 143-*621 et. seq.*, which authorized the Health Purchasing Alliance Board to establish small group purchasing alliances, with the goal of pooling together small employers to enable the groups to negotiate the same lower rates charged large employers.

VI. COMMISSION RECOMMENDATIONS

The Health Planning Commission recommendations are listed in a separate document, entitled Commission recommendations. In general, the recommendations cover eight areas: 1) expanding coverage to the uninsured, 2) controlling rising health care costs, 3) expanding services in rural and urban medically underserved areas, 4) changing the focus of the current health system from a curative medical system to one that focuses on keeping people healthy, 5) ensuring high quality services, 6) establishing a data and information system capable of meeting the health information needs of the future, 7) ensuring that the health needs of at-risk populations are met, and 8) general recommendations for continuing the work of the Commission.

Appendix A

Authorizing Legislation

GENERAL ASSEMBLY OF NORTH CAROLINA
1993 SESSION
RATIFIED BILL

CHAPTER 529
HOUSE BILL 729

AN ACT TO PROVIDE FOR HEALTH CARE REFORM PLANNING, SMALL EMPLOYER PURCHASING GROUPS, REORGANIZATION OF STATE HEALTH FUNCTIONS INTO A STATE DEPARTMENT OF HEALTH, THE CREATION OF COMMUNITY HEALTH DISTRICTS, UNIFORM HEALTH CLAIM FORMS, HOSPITAL COOPERATION AGREEMENTS, AND HEALTH DELIVERY IMPROVEMENTS.

The General Assembly of North Carolina enacts:

PART I.--HEALTH CARE REFORM PLANNING

Section 1. (a) This act shall be known as the "Jeralds - Ezzell - Fletcher Health Care Reform Act of 1993".

(b) The General Assembly makes the following findings:

(1) More than 1,000,000 North Carolina citizens are uninsured on an average day, and an additional number are underinsured.

(2) North Carolina citizens who are uninsured and underinsured lack access or have limited access to health care, especially to cost-effective primary and preventive care, which may result in poor health, illness, and death.

(3) The health care received by uninsured and underinsured individuals is obtained primarily through public programs, and is financed by cost shifting which places an unfair financial burden on those who can pay, especially on employers who provide health care coverage for their employees.

(4) Health care costs in North Carolina and nationwide are rising much more rapidly than incomes, and the disparity will continue to grow over time unless health care reform is enacted.

(5) The increasing numbers of uninsured and underinsured individuals in North Carolina and the escalating costs of health care are so interrelated that it is not possible to guarantee access to health care for all North Carolina citizens without containing health care costs.

(6) Given the scope and complexity of health reform, the General Assembly expects the necessary changes to take years, and for the results to extend well into the next century. Purchasing alliances for small employers should provide accessibility and affordability of health care in an employer-based system as the General Assembly plans for these changes.

(7) In order to improve the health status of every North Carolinian, it is necessary for each citizen to have access to appropriate health

services delivered by a broad range of health providers who are either licensed or certified in North Carolina.

(8) Appropriate health services can be provided most effectively within each of several local health communities.

(9) Within each health community every citizen shall be able to select the primary care provider of choice and, in return, every citizen shall be held accountable for a healthy lifestyle.

(10) The health providers in each of the several communities shall be held accountable for the health of that community and shall cooperate and collaborate to that end.

(11) In order to ensure that each local health community can address its unique health problems adequately, the State shall provide assessment, assurance, and assistance.

(12) The State's support of local health communities shall be through a State Department of Health whose principal role is to assist local health communities to develop individual solutions to health problems.

Sec. 1.1. Chapter 58 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 68A.

"Health Care Reform Planning.

"§ 58-68-21. Short title; legislative intent.

The General Assembly finds that in order to provide access and contain costs it is necessary to plan for the restructuring of the financing and delivery of health care in this State. It is the intent of the General Assembly to:

(1) Develop a universal health care program to provide all North Carolina residents access to quality health care that is comprehensive and affordable.

(2) Implement the universal health care program only when:

a. A national mandate for universal coverage takes effect; or

b. Waivers have been obtained exempting North Carolina from ERISA and if necessary, from Medicaid and Medicare; or

c. The General Assembly has determined that it can implement a universal health care program within existing law and determines it would not adversely affect the economy and the business climate in North Carolina.

(3) Establish a commission to reorganize North Carolina's citizenry in improving its health and to develop the universal health care program.

(4) Focus health reform upon improving health status and the included health care.

(5) Encourage local communities to develop local solutions to health problems which will require the local community to create a board, representative of the citizenry, which shall guide the health affairs of the community, assign health priorities, and allocate health resources.

(6) Ensure that the reform mechanisms implemented recognize the roles of all health professionals who are either licensed or certified in North Carolina in improving the health status of the citizenry of North Carolina.

"§ 58-68-22. Definitions.

As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) 'Community health plan' means any privately administered health service plan or any other mode of delivery of health care that is certified by a regional health plan purchasing cooperative and that provides health care services to eligible residents in exchange for a prescribed charge paid pursuant to the program of universal health coverage established by this Article.

(2) 'Commission' means the North Carolina Health Planning Commission established pursuant to Article 65 of Chapter 143 of the General Statutes.

(3) 'Eligible resident' means an individual who has been legally domiciled in this State for a period of 30 days. For purposes of this Article, legal domicile is established by living in this State and obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return. A child is legally domiciled in this State if the child lives in this State and if at least one of the child's parents or the child's guardian is legally domiciled in this State for a period of 30 days. A person with a developmental disability or another disability which prevents the person from obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return, is legally domiciled in this State by living in the State for 30 days.

(4) 'Federal poverty income level' means the federal official poverty line, as defined by the Federal Office of Management and Budget, based on Bureau of Census data, and revised annually by the Secretary of Health and Human Services pursuant to section 9902(2) of Title 42 of the United States Code.

(5) 'Plan' means the North Carolina Health Plan described in this Article.

(6) 'Regional health plan purchasing cooperative' means an organization established to administer the Plan in a geographic area of the State.

"**§ 58-68-23. North Carolina Health Plan.**

The Commission may design a plan for a system of universal health care coverage to be known as the North Carolina Health Plan. The Plan, when implemented, will provide all eligible residents the same guaranteed package of comprehensive, medically necessary health care services, including primary and preventive care. These health care services will be provided through community health plans that will accept all eligible residents regardless of health status, and without individual medical underwriting, preexisting condition exclusions, or waiting periods. The Plan shall address the following elements:

(1) Financing. -- A method or methods of financing the Plan shall be recommended by the Commission. The system which will ensure that every North Carolina citizen has access to affordable health care, regardless of the resources of the community in which he resides.

(2) Cost Containment. -- Costs shall be contained by encouraging competition among community health plans on the basis of price and quality, reducing administrative costs, providing incentives for health care providers to participate in managed-care systems, ensuring appropriate growth in medical technology, and through any other methods that will contain health care costs without impairing the quality of services.

(3) Provider Fees and Practice Parameters. -- The Plan shall address the following aspects of provider fees and practice parameters:

a. Global per case reimbursement including both professional and institutional providers;

b. Resource-Based Relative Value Scale (RBRVS) fee schedules for all other physician reimbursement; and

c. The use of physician practice guidelines for reimbursement and utilization review purposes only.

(4) Benefit Package. -- A benefit package shall be developed by the Commission similar to the most commonly purchased Health Maintenance Organization (HMO) benefit package in the State. The Commission's benefit package shall include patient cost-sharing, except there shall be full coverage with no deductible and no copayments for prenatal care, well child care, periodic physical examinations, and other health screenings and services as recommended by the U.S. Preventive Services Task Force 'Guide to Clinical Preventive Services'. Cost-sharing for eligible residents below one hundred percent (100%) of the federal poverty income level shall not exceed Medicaid-allowable amounts. Cost-sharing for eligible residents between one hundred percent (100%) and two hundred fifty percent (250%) of poverty shall be based on a sliding scale. The Commission shall develop maximum out-of-pocket limits.

(5) Administration. -- The Plan may be administered through regional health plan purchasing cooperatives that will:

a. Certify private health plans as community health plans for participation in the system of universal health coverage on the basis of ability to deliver the State-guaranteed package of comprehensive, medically necessary health services in accordance with criteria defined by the Commission for quality and service. All community health plans meeting certification requirements will be certified.

b. Pay each community health plan the same risk-adjusted per capita amount for all eligible persons, except that the Commission shall have the authority to ensure accessibility to health care in rural and medically underserved areas by enhancing provider payments, requiring an accountable health plan to provide services throughout the area, or by any other reasonable means.

c. Ensure that no community health plan that charges an additional premium shall charge an eligible resident a higher premium than that charged to any other eligible resident for the same accountable health plan.

d. Except in underserved areas in which the regional health plan purchasing cooperative determines that there are insufficient providers to support more than one community health plan, ensure that all eligible residents have a choice of at least two community health plans that will provide the State-guaranteed package of comprehensive, medically necessary health services for no additional premium above that paid on their behalf by the regional health plan purchasing cooperative.

e. Assist eligible residents in choosing among community health plans by providing consumer education, including uniform information about all the community health plans available through the health plan purchasing cooperative such as quality indicators and choice of providers.

f. Provide a mechanism for enrolling all eligible residents in their chosen community health plans and for automatically enrolling in a community health plan all eligible residents who fail to choose such a plan.

g. The number, organization, and geographic areas of the regional health plan purchasing cooperatives to be established, which will include at least six geographic areas. Each area is to be defined so that it is self-sufficient in providing comprehensive health care including most tertiary services, thus allowing for a large enough population to support community rating.

h. Monitor and enforce standards concerning access, consumer satisfaction, and quality of care in all community health plans.

i. Jointly with the Commission and the North Carolina Medical Database Commission, collect data from all community health plans and sponsor research into health outcomes and practice guidelines.

j. Jointly with the Commission and where necessary to meet the needs of underserved areas or special populations, organize the delivery of health care.

k. Receive bids annually from private health plans to provide the benefit package established by the Commission to enrolled eligible residents. A health plan purchasing cooperative may reject any or all bids, and may request that revised bids be submitted.

(6) Large Groups. -- In order to preserve employer-based and other group health care coverage, the Plan may provide, notwithstanding any other provision of this Article, for the direct marketing by community health plans to an employer with 100 or more employees and to any other group with 100 or more members, provided that the employer or group is eligible under G.S. 58-51-80 for group accident, group health, or group accident and health insurance. If the Plan provides for direct marketing of insurance to large groups as defined in this subsection, it shall also address the extent to which those groups and self-insured plans (prior to obtaining an ERISA waiver) should be subject to the certification requirements for community health plans, whether exemptions, tax credits, or other means are necessary and appropriate to provide for equitable treatment of large groups and self-insured groups under any tax-financed system of universal health care coverage, and other issues involving the use of large group coverage with universal coverage. The regional health plan purchasing cooperatives would be responsible for marketing community health plans to individuals and all other groups. Before the plan provides for direct marketing to large groups, the Commission shall study whether there are any adverse affects to the purchasing arrangements in effect for other residents, the impact on portability

of coverage, and the role large employers play in financing coverage for the uninsured and indigent populations."

Sec. 1.2. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 65.

"North Carolina Health Planning Commission.

"§ 143-610. Definitions.

As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) 'Community health plan' means any privately administered health service plan or any other mode of delivery of health care that is certified by a regional health plan purchasing cooperative and that provides health care services to eligible residents in exchange for a prescribed charge paid pursuant to the program of universal health coverage established by this Article.

(2) 'Commission' means the North Carolina Health Planning Commission.

(3) 'Eligible resident' means an individual who has been legally domiciled in this State for a period of 30 days. For purposes of this Article, legal domicile is established by living in this State and obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return. A child is legally domiciled in this State if the child lives in this State and if at least one of the child's parents or the child's guardian is legally domiciled in this State for a period of 30 days. A person with a developmental disability or another disability which prevents the person from obtaining a North Carolina motor vehicle operator's license, registering to vote in North Carolina, or filing a North Carolina income tax return, is legally domiciled in this State by living in the State for 30 days.

(4) 'Federal poverty income level' means the federal official poverty line, as defined by the Federal Office of Management and Budget, based on Bureau of Census data, and revised annually by the Secretary of Health and Human Services pursuant to section 9902(2) of Title 42 of the United States Code.

(5) 'Plan' means the North Carolina Health Plan described in this Article.

(6) 'Regional health plan purchasing cooperative' means an organization established to administer the Plan in a geographic area of the State.

"§ 143-611. Commission established; members; terms of office; quorum; compensation.

(a) Establishment. -- There is established the North Carolina Health Planning Commission with the powers and duties specified in this Article. The Commission shall be located within the Office of the Secretary, Department of Human Resources, for organizational, budgetary, and administrative purposes.

(b) Membership and Terms. -- The Commission shall consist of 16 members, as follows:

(1) The Governor;

(2) The Lieutenant Governor;

(3) The Speaker of the House of Representatives;

(4) The President Pro Tempore of the Senate;

(5) Five members of the House of Representatives appointed by the Speaker of the House of Representatives;

(6) Five members of the Senate appointed by the President Pro Tempore of the Senate; and

(7) The following nonvoting members, ex officio:

a. The Secretary of the Department of Environment, Health, and Natural Resources; and

b. The Secretary of the Department of Human Resources.

(c) Compensation. -- The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, 138-5, and 138-6, as applicable.

(d) Meetings. -- The Governor shall convene the Commission. Meetings shall be held as often as necessary, but not less than six times a year.

(e) Quorum. -- A majority of the voting members of the Commission shall constitute a quorum for the transaction of business. The affirmative vote of a majority of the members present at meetings of the Commission shall be necessary for action to be taken by the Commission.

"**§ 143-612. Powers and duties of the Commission.**

(a) Administrative Powers. -- The Commission shall have the following administrative powers:

(1) To appoint a director, who shall be exempt from the State Personnel Act, and to employ other staff as it deems necessary, subject to the State Personnel Act, and to fix their compensation;

(2) To enter into contracts to carry out the purposes of this Article;

(3) To conduct investigations and inquiries and compel the submission of information and records the Commission deems necessary; and

(4) To accept grants, contributions, devises, bequests, and gifts for the purpose of providing financial support to the Commission. Such funds shall be retained by the Commission.

(b) Plan Development. -- The Commission may develop a Plan, for submission to the General Assembly. If the Commission develops a Plan in accordance with G.S. 58-68-23, the Plan may incorporate the following:

(1) Annual review of the benefits package;

(2) Annual budget targets;

(3) Cost-containment measures to meet established annual budget targets;

(4) Independent actuarial cost estimates for the recommended benefit package;

(5) The amount of appropriations needed to finance the Plan;

(6) The methodology to be used in making risk-adjusted payments to the community health plans;

(7) The standards for eligibility for the Plan in addition to those contained in G.S. 58-68-22(3) and G.S. 143-610(3);

(8) Accessibility to health care in rural and medically underserved areas through the enhancement of provider payments, requiring community health plans to provide services throughout their area, or by any other reasonable means;

(9) Supplemental health benefits for all eligible residents including employees of business entities; and

(10) The economic impacts of implementing the Plan, including overall costs to the State economy, costs to the State's business economy, costs to the State, impact on future State economic development, immediate effects on the job market in the State, and a 10-year projection of these items if the Plan is not implemented.

(c) Plan Study. -- The Commission shall also study the following issues and may recommend to the General Assembly actions to address these issues:

(1) The steps necessary to include the populations served by Medicaid, including a statement of any necessary federal waivers;

(2) The steps necessary to obtain an exemption from the federal Employee Retirement and Income Security Act (ERISA);

(3) Examine the roles of other existing publicly financed systems of health coverage such as Medicare, federal employee health benefits, health benefits for armed services members, the Veterans Administration, the CHAMPUS program (10 U.S.C. § 1071 et seq.), and any other health benefits currently mandated by State or federal law or funded by State agencies;

(4) Whether existing retirement health benefits may be included in the Plan;

(5) The mechanisms for ensuring that the Plan will provide appropriate access to quality medical services for all eligible residents;

(6) The means by which the Plan will ensure that the needs of special populations of eligible residents such as low-income persons, people living in rural and underserved areas, and people with disabilities and chronic or unusual medical needs will be met;

(7) The role of the existing county health care system in the Plan;

(8) Proposals for consolidation of the health care components of workers' compensation and automobile insurance with the health coverage provided under the Plan to avoid duplication of coverage;

(9) The appropriate means of financing medical education and medical research;

(10) The appropriate method of collecting data for both quality assurance and cost containment, and in guiding the proliferation of new medical technologies;

(11) The means by which North Carolina's need for long-term care services can best be met, including an examination of the appropriateness and availability of home and community-based services;

(12) Whether medical malpractice tort reforms are needed, and, if so, the tort reforms needed;

(13) The development of medical practice parameters;

(14) The need for rate-setting in areas where sufficient competition does not exist;

(15) The need for the collection of data prior to implementation of the Plan and develop, if necessary, recommendations for the collection of such data;

(16) The impact of the Plan on small businesses and methods to alleviate undue financial burdens on small businesses, including, but not limited to, a specified monthly level of payroll upon which no assessment is made;

(17) The impact of the Plan on continued group health insurance for large groups;

(18) The use of licensed insurance agents and producers in the enrollment, education, and provision of service to eligible residents;

(19) The need for and methods to accomplish global budgeting;

(20) Methods to ensure adequate primary care for all eligible residents, and appropriate compensation for primary care services to achieve that end;

(21) Methods to increase the number of mobile health care units that provide services to communities that are underserved with respect to health care;

(22) The impact on health care cost and efficiency of rule changes made by State and local government agencies pertaining to health care services. The study shall include the impact of the frequency of such rule changes;

(23) The relationship between the Plan, regional health plan purchasing cooperatives, community health districts, a Department of Health, the Commission, and the Health Care Purchasing Alliances established under G.S. 143-627;

(24) The establishment of a health care trust fund in the State Treasurer's Office to serve as a depository for the following:

a. All revenues collected from taxes and other sources enacted for the purpose of funding the Plan;

b. All federal payments received as a result of any waiver of requirements granted by the United States Secretary of Health and Human Services under health care programs established under Title XIX of the Social Security Act, as amended; and

c. All moneys appropriated by the North Carolina General Assembly for carrying out the purposes of the Plan.

(25) Identification of need for additional benefits and population-based services to be offered in the community, based on the established priorities for improving community health status in the community;

(26) Mechanisms to provide for the continuing education and training of health care personnel and community health district boards; and

(27) Review of community health districts' reports and establishment of priorities for programs and financing to address community health district needs.

(d) Notwithstanding any other provision in this Article or Article 68A of Chapter 58 of the General Statutes, the Commission may develop its own health care proposals or plans or make any other recommendations to the General Assembly.

(e) The Commission shall appoint such advisory, technical, and professional panels as it deems necessary to advise it on the performance and administration of its functions. Each panel shall consist of experts drawn from the health professions, health educational institutions, providers of services, insurers, and other sources, including consumers. At least three panels shall be established to advise, consult with, and make recommendations to the Commission on the development, maintenance, funding, evaluation, and priorities of community health services.

"**§ 143-614. Reports.**

(a) The Commission shall submit to the General Assembly, no later than April 1, 1994, the following:

(1) An outline for the development of a Health Care Reform Plan.

(2) The implementation plan for Phases I and II, as required under Section 1.4 of this act.

(3) A progress report on the study of issues on Health Care Reform pursuant to G.S. 143-612(c).

(b) The Commission shall submit to the General Assembly, no later than April 1, 1995, the following:

(1) A progress report on the development of a Health Care Reform Plan.

(2) The implementation plan for Phase III, as required under Section 1.4 of this act.

(3) Recommendations resulting from the study of issues on Health Care Reform pursuant to G.S. 143-612(c).

(c) The Commission shall thereafter report annually to the General Assembly on its activities, findings, and recommendations. Reports shall be submitted no later than April 1 of each year."

Sec. 1.3. Section 78 of Chapter 321 of the 1993 Session Laws reads as rewritten:

"Sec. 78. (a) Funds appropriated in this act to the Board of Governors of The University of North Carolina for continuation of financial assistance to the medical schools of Duke University and Wake Forest University shall be disbursed on certifications of the respective schools of medicine that show the number of North Carolina residents as first-year, second-year, third-year, and fourth-year students in the medical school as of November 1, 1993, and November 1, 1994. Disbursement to Wake Forest University shall be made in the amount of eight thousand dollars ($8,000) for each medical student who is a North Carolina resident, one thousand dollars ($1,000) of which shall be placed by the school in a fund to be used to provide financial aid to needy North Carolina students who are enrolled in the medical school. The maximum aid given to any student from this fund in a given year may not exceed the amount of the difference in tuition and academic fees charged by the school and those charged at the School of Medicine at the University of North Carolina at Chapel Hill.

Disbursement to Duke University shall be made in the amount of five thousand dollars ($5,000) for each medical student who is a North Carolina resident, five hundred dollars ($500.00) of which shall be placed by the school in a fund to be used to provide student financial aid to financially needy North Carolina students who are enrolled in the medical school. No individual student may be awarded assistance from this fund in excess of two thousand dollars ($2,000) each year. In addition to this basic disbursement for each year of the biennium, a disbursement of one thousand dollars ($1,000) shall be made for each medical student who is a North Carolina resident in the first-year, second-year, third-year, and fourth-year classes to the extent that enrollment of each of those classes exceeds 30 North Carolina students.

The Board of Governors shall establish the criteria for determining the eligibility for financial aid of needy North Carolina students who are enrolled in the medical schools and shall review the grants or awards to eligible students. The Board of Governors shall adopt rules for determining which students are residents of North Carolina for the purposes of these programs. The Board of Governors shall also make any regulations as necessary to ensure that these funds are used directly for instruction in the medical programs of the schools and not for religious or other nonpublic purposes.

(a1) In recognition of North Carolina's need for primary care physicians, Bowman Gray School of Medicine and Duke University School of Medicine shall each prepare a plan with the goal of encouraging North Carolina residents to enter the primary care disciplines of general internal medicine, general pediatrics, family medicine, obstetrics/gynecology, and combined medicine/pediatrics and to strive to have at least fifty percent (50%) of North Carolina residents graduating from each school entering these disciplines. These schools of medicine shall present their plans to the Board of Governors of The University of North Carolina by April 15, 1994. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by

May 15, 1994, on the status of these efforts to strengthen primary health care in North Carolina.

(b) The Board of Governors of The University of North Carolina shall set goals for the Schools of Medicine at the University of North Carolina at Chapel Hill and the School of Medicine at East Carolina University for increasing the percentage of graduates who enter residencies and careers in primary care. A minimum goal should be at least ~~fifty~~ sixty percent ~~(50%)~~ (60%) of graduates entering primary care disciplines. Each school shall submit a plan with strategies to reach these goals of increasing the number of graduates entering primary care disciplines to the Board by April 15, 1994. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1994, on the status of these efforts to strengthen primary health care in North Carolina.

Primary care shall include the disciplines of family medicine, general pediatric medicine, general internal medicine, internal medicine/pediatrics, and obstetrics/gynecology.

(c) The Board of Governors of The University of North Carolina shall further initiate whatever changes are necessary on admissions, advising, curriculum, and other policies for State-operated medical schools to ensure that larger proportions of medical students seek residencies in primary care disciplines. The Board shall work with the Area Health Education Centers and other entities, adopting whatever policies it considers necessary to ensure that residency programs have sufficient medical residency positions for medical school graduates in these primary care specialties.

(d) The progress of the private and public medical schools towards increasing the number and proportion of graduates entering primary care shall be monitored annually by the Board of Governors of The University of North Carolina. Monitoring data shall include (i) the entry of State-supported medical graduates into primary care residencies, and (ii) the specialty practices by a physician as of a date five years after graduation. The Board of Governors shall certify data on graduates, their residencies, and subsequent careers by October 1 of each calendar year, beginning in October of 1995, to the Fiscal Research Division of the Legislative Services Office and to the Joint Legislative Education Oversight Committee.

(e) The information provided in subsection (d) of this section shall be made available to the Appropriations Committees of the General Assembly for their use in future funding decisions on medical education.

(f) Subsection (a1) of this section shall be codified as G.S. 143-613(a). Subsection (b) of this section shall be codified as G.S. 143-613(b). Subsection (c) of this section shall be codified as G.S. 143-613(c). Subsection (d) of this section shall be codified as G.S. 143-613(d). Subsection (e) of this section shall be codified as G.S. 143-613(e). The catch line of G.S 143-613 shall read as follows:

"**§ 143-613. Medical education; primary care physicians.**"

Sec. 1.4. (a) It is the intent of the General Assembly that the North Carolina Health Planning Commission develop a Health Care Reform Plan and that a new commission be appointed in the future to oversee implementation of the Plan. The new Commission would be a seven-member panel appointed by the Governor, subject to confirmation by the General Assembly, and would be appointed at least six months prior to the Plan's effective date.

(b) The North Carolina Health Planning Commission, in preparing for this transition, shall develop (i) a phased implementation program for the Plan to coincide with a mandate or anticipated mandate for universal coverage, a federal preemption for North Carolina, or the date established by the General Assembly after it has determined that it can implement a universal health care program within existing laws, and (ii) a phased implementation plan for insurance reforms. The Plan

shall incorporate the following structure for implementation. Phases I and II are interim measures until the General Assembly enacts a universal health coverage plan. Phase III is to be implemented in accordance with G.S. 58-68-21(2).

Phase I: The Small Employer Group Health Insurance Coverage Reform Act is expanded from employers with up to 25 employees to employers of up to 49 employees, pursuant to Chapter 408 of the 1993 Session Laws. Rating band restrictions for the individual market would also be instituted, to be phased in over a period of time.

Phase II: The Small Employer Group Health Insurance Coverage Reform Act would be expanded to employers with up to 99 employees. Community rating would begin to be implemented, with incremental implementation of rating bands. All carriers would be required to implement community health plan qualifications.

Phase III: Rating bands would be removed to fully implement adjusted community rating. Cost-containment measures would be implemented.

Sec. 1.5. The Department of Insurance and the Executive Administrator and the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall provide technical assistance to the North Carolina Health Planning Commission upon request, including assistance on statutory changes required in Chapters 58 and 135 of the General Statutes in order to effectuate the Plan.

Sec. 1.6. Of the funds appropriated to the Reserve for Health Care Initiatives in Chapter 321 of the 1993 Session Laws, the sum of one million five hundred thousand dollars ($1,500,000) for the 1993-94 fiscal year and the sum of one million five hundred thousand dollars ($1,500,000) for the 1994-95 fiscal year shall be used for the operation of the North Carolina Health Planning Commission and for other activities related to the duties and responsibilities of the Commission pursuant to this Act.

Sec. 1.7. Nothing in this Part shall be construed to give the North Carolina Health Planning Commission authority to implement any Plan for health care reform developed under this Part. A Plan developed under this Part shall not be implemented without additional authorizing legislation from the General Assembly.

Sec. 1.8. Section 1.6 of this act becomes effective July 1, 1993.

PART II.--DEPARTMENT OF HEALTH AND COMMUNITY HEALTH DISTRICTS

Sec. 2.1. (a) From the least fortunate to those with greatest wealth in this State, there is near universal concern over the current health system. Strong and effective preventive health services must not only be designed but implemented. The people in this State, wherever they happen to reside, shall have access to comparable levels of health services at reasonable costs. Lack of access for hundreds of thousands of North Carolinians, and a host of unacceptable health indices, require a carefully constructed plan for reform. If the State is to face this responsibility, it will require consolidation of planning and oversight of many presently scattered health programs. Fundamental health reform demands clear accountability. Accountability is impossible when many different departments and divisions of government have responsibility.

(b) The Governor shall present to the General Assembly no later than April 1, 1994, a plan for consolidating all of the State health functions into one State Department of Health. The plan shall be based upon and shall address the principles and elements outlined in subsections (c) and (d) of this section.

(c) The Governor's plan as required under subsection (b) of this section shall be based on the following principles:

(1) Improved health status - not health care - should be the ultimate goal;

(2) Health status must be improved primarily through locally developed initiatives;

(3) The appropriate role of the State is to assure a framework by which health services can be delivered in local communities;

(4) While State and local governments should provide the framework for the delivery of health services, they should not interpret this responsibility as a requirement to directly provide all of these services;

(5) In order for a new health system to be effective, there must be cooperative and collaborative efforts in place throughout the State. Hospitals, health departments, individual health providers, provider organizations, and others must find new and innovative ways to work together effectively.

(d) The Plan required under subsection (b) of this section shall be based on the following elements:

(1) A Department of Health encompassing at least all health functions now residing in the Department of Human Resources, Department of Environment, Health, and Natural Resources, the North Carolina Medical Database Commission, and any other functions assigned by the General Assembly or Governor to State agencies relating to health care.

(2) Expansion of the Commission for Health Services to include a membership comprised of health experts, business leaders, and consumers, and the appointment of a State Health Secretary by the Governor to head the Department of Health. The expanded Commission may be developed and created before the Department comes into existence. Such a Commission should be placed within the Department of Human Resources until such time as the Department of Health is created.

(3) The Department of Health shall promote and organize "Community Health Districts". Community Health Districts shall represent the locus of health policy and delivery for the designated communities they serve. All governmental health-related activities will be conducted under the auspices of the District. Each District shall have a local District Board of Health whose members shall be appointed by the County Boards of Commissioners of each county within the District.

(4) The State Health Department and Commission for Health Services shall establish scientifically based indicators of health quality. The Community Health District shall be responsible for implementation of disease prevention, local health regulation, and health care delivery for the community pursuant to broad guidelines established by the Commission for Health Services.

(5) A "Community Health Status Assessment" shall be performed on a regular basis in each Community Health District in order to provide the information needed to implement the purposes and programs of the Board. The assessment shall include, but not be limited to:

a. Epidemiological research of community including age, sex, racial, and geographic factors.

b. Environmental health risk factors.

c. Availability, access, and utilization of prevention programs (medical, dental, educational).
d. Mental health and substance abuse factors.
e. Outcomes of health care programs and services in the District.
f. An estimate of the total private and public financial resources necessary to meet health needs within the District.
g. A survey of the health facilities available to meet the needs of hospitals, community clinics, school clinics, and high technology treatment facilities available outside hospitals.
h. A survey of the health care personnel and related human resources available to meet the health care needs of the District.
i. Priorities for improving community health status.

PART III.--SMALL EMPLOYER PURCHASING GROUPS

Sec. 3.1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 66.

"Health Care Purchasing Alliance Act.

"**§ 143-621. Purpose and intent.**

The purpose and intent of this Article is to increase the affordability, efficiency, and fairness of health coverage for small employers.

The Article promotes the development of voluntary purchasing Alliances to provide affordable health care coverage for self-employed individuals and employees of participating small employers in the manner of large employer groups. The Alliances will allow members to benefit from the contracting expertise and the administrative savings that can result from the pooling of small employers and self-employed individuals.

These Alliances will make available through their contracting processes a choice of Accountable Health Carriers that arrange for quality health services in a cost-effective manner. The Article establishes rules for fair competition among competing Accountable Health Carriers. These rules include the offering of comparable benefits by competing Accountable Health Carriers, risk assessment, and risk adjustment to assure competition based on a fair allocation of risk among Accountable Health Carriers, and the providing of data that measures clinical outcomes and other valid areas of Accountable Health Carrier performance.

Carriers throughout the health coverage market for small employers are required to use adjusted community rating, guarantee the continuity of coverage, adhere to limitations on the use of preexisting conditions, abolish individual medical underwriting, and follow rules limiting the use of participation requirements.

"**§ 143-622. Definitions.**

As used in this Article:

(1) 'Accountable Health Carrier' means a carrier registered with the Board pursuant to G.S. 143-626.

(2) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments only for the following demographic factors: age, gender, number of family members covered, and geographic areas, as determined pursuant to G. S. 58-50-130(b).

(3) 'Alliance' means a State-chartered, nonprofit organization that provides health insurance purchasing services to member small employers in a market area regarding qualified health care plans offered by Accountable Health Carriers established pursuant to G.S. 143-629.

(4) 'Alliance Board' means the Alliance Board of Directors for a market area established pursuant to G.S. 143-627.

(5) 'Antitrust laws' means federal and State laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.

(6) 'Board' means the State Health Plan Purchasing Alliance Board.

(7) 'Carrier' means that as defined in G.S. 58-50-110(5).

(8) 'Community sponsor' means an organization that assumes responsibility for serving as the host for an Alliance in a market area.

(9) 'Dependent' means that as defined in G.S. 58-50-110(9).

(10) 'Eligible employee' means that as defined in G.S. 58-50-110(10).

(11) 'Employee enrollee' means an eligible employee or dependent of an eligible employee who is enrolled in a qualified health care plan.

(12) 'Fund' means the State Health Plan Purchasing Alliance Fund established under G.S. 143-635.

(13) 'Grievance procedure' means an established set of rules that specify a process for appeal of an organizational decision.

(14) 'Health benefit plan' means that as defined in G.S. 58-50-110(11).

(15) 'Late enrollee' means an eligible employee or a dependent of an eligible employee who requests enrollment in a qualified health care plan after the initial enrollment period for a member small employer, provided the enrollment is consistent with the Alliance's rules for initial enrollment and provided that the initial enrollment period shall extend for at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided at least the minimum level of benefits in qualified health care plans established pursuant to G.S. 58-50-120 at the time the individual was eligible to enroll and either:

1. Lost coverage under another health plan as a result of termination of employment, the termination of coverage under another health plan, or the death of a spouse or divorce and requests enrollment in a qualified health care plan within 30 days after termination of coverage; or

2. Stated, in writing, during the enrollment period that coverage under another employer's health benefit plan was the reason for declining coverage;

b. The individual elects a different health plan offered through an Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit

plan and the request for enrollment is made within 30 days after issuance of the court order; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of his or her marriage or the birth or adoption of a child.

(16) 'Lowest cost plan' means the lowest cost qualified health care plan selected by a member small employer and offered to the employer's employee enrollees.

(17) 'Market area' means a clearly defined, nonoverlapping, and exclusive geographical area determined by the Board for the purpose of defining the region in which an Alliance shall operate.

(18) 'Member small employer' means a small employer who enrolls in an Alliance.

(19) 'Preexisting condition provision' means that as defined in G.S. 58-50-110(17).

(20) 'Premium' means that as defined in G.S. 58-50-110(18).

(21) 'Qualified health care plans' means the basic or standard health care plans offered by an Accountable Health Carrier to member small employers and as authorized by the Small Employer Carrier Committee pursuant to G.S. 58-50-120.

(22) 'Risk adjustment mechanism' means the process established pursuant to G.S. 143-633.

(23) 'Self-employed individual' means that as defined in G.S. 58-50-110(21a).

(24) 'Service area' means a geographic region in which a carrier is licensed to operate.

(25) 'Small employer' means that as defined in G.S. 58-50-110(22).

"§ 143-623. Health benefit plans subject to Article.

A health benefit plan is subject to this Article if it provides health benefits for small employers and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium;

(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purposes of Sections 106, 125, or 162 of the United States Internal Revenue Code; or

(3) The small employer has permitted payroll deductions for the eligible enrollees for the health benefit plans.

"§ 143-624. Jurisdiction of the Department of Insurance.

Nothing in this Article shall be deemed to be in conflict with or in limitation of the duties and powers granted to the Commissioner of Insurance under Chapter 58 of the General Statutes. The Board and Alliances established under this Article shall bring to the attention of the Department of Insurance any suspected or alleged violations of this Article.

"§ 143-625. Establishment of the Board; membership; terms; personnel.

(a) There is established the State Health Plan Purchasing Alliance Board. The Board shall be established within the Department of Administration for administrative, organizational, and budgetary purposes only. The Department of Administration shall provide administrative and staff support to the Board. The Department of Insurance shall provide technical assistance as requested by the Board.

(b) The Board shall consist of 11 members, as follows:

(1) Three appointed by the Governor, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(2) Three appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, in accordance with G.S. 120-121, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(3) Three appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(4) The Lieutenant Governor or his or her representative; and

(5) The Commissioner of Insurance or his or her representative.

(c) Members of the Board who are not officers or employees of the State shall receive compensation of two hundred dollars ($200.00) for each day or part of a day of service plus reimbursement for travel and subsistence expenses at the rates specified in G.S. 138-5. Members of the Board who are officers or employees of the State shall receive reimbursement for travel and subsistence at the rates specified in G.S. 138-6.

(d) Appointed members shall serve for four-year terms except that the initial terms of:

(1) Two members appointed by the Governor, two members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, shall expire July 1, 1995; and

(2) One member appointed by the Governor, one member appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and two members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, shall expire July 1, 1997.

(e) At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed. A member who serves two consecutive full four-year terms shall not be reappointed until four years after completion of those terms. A vacancy in a legislative appointment shall be filled in accordance with G.S. 120-122.

(f) The Board shall elect officers biennially. Officers shall serve no more than two consecutive terms in an office.

(g) The Board shall appoint an executive director who shall serve at the pleasure of the Board. The executive director shall administer the affairs of the Board. The executive director may employ and direct staff necessary to carry out the provisions of this Article. Staff of the Board shall be covered under the State Personnel Act.

(h) The Board shall meet as needed at the times and places it determines. Such meetings and procedures shall be governed by the procedures and policies set forth in

the North Carolina Open Meetings Law, Article 33C of Chapter 143 of the General Statutes. A majority of the fully authorized membership of the Board is a quorum.

(i) No Board members or their spouses shall be employed by, affiliated with an agent of, or otherwise a representative of any carrier or health care provider.

(j) No individual shall be appointed to or remain a member of the Board if the individual, the individual's spouse, or the individual and spouse together, held securities or are otherwise the beneficiaries of securities worth ten thousand dollars ($10,000) or more at fair market value as of December 31 of the preceding year in a single health care business or aggregated among multiple health care businesses. For the purposes of this subsection, the term, 'health care business':

(1) Includes an association, corporation, enterprise, joint venture, organization, partnership, proprietorship, trust, and every other business interest that provides or insures human health care.

(2) Does not include a widely held investment fund, regulated investment company, or pension or deferred compensation plan if neither the individual nor the individual's spouse has the ability to exercise control over the financial interests held by the fund.

"**§ 143-626. Duties of the Board.**

The Board shall:

(1) Establish no less than four and no more than 12 market areas in this State. In establishing such market areas, the Board shall ensure that every location is a part of a market area. To the largest extent possible, the Board should consider metropolitan standard areas and other existing markets. The Board may redefine market areas where it determines there will be insufficient numbers of enrollees, health care providers, or qualifying Accountable Health Carriers to make such requirements feasible. Any such modifications are subject to annual review by the Board.

(2) Accept applications by carriers to qualify as Accountable Health Carriers, determine the eligibility of carriers to become Accountable Health Carriers according to criteria described in G.S. 143-629, and designate carriers as Accountable Health Carriers.

(3) Establish Alliances with community sponsors pursuant to G.S. 143-627 for each market area determined by the Board.

(4) Conduct annual reviews of the performance of each Alliance to ensure that the Alliance is in compliance with this Article. To assist the Board in its review, each Alliance shall submit data to the Board quarterly including, but not limited to, employer enrollment by employer size; industry sector; previous insurance status and number of employees within each insurance status; number of total eligible employers in the market area participating in the Alliance; number of insured lives by county and insured category, including employees, dependents and other insured categories, represented by Alliance members; profiles of potential employer membership by county; premium ranges for each qualified health care plan for Alliance member categories; type and resolution of member grievances; surcharges; and Alliance financial statements. A summary of this annual review shall be provided to the General Assembly and each Alliance.

(5) Develop standard enrollment procedures to be used in enrolling small employers and their eligible employees.

(6) Establish conditions of participation for small employers and self-employed individuals which shall conform to the requirements of this Article and G. S. 58-50-125(d) and include, but not be limited to, the following:

a. Assurances that the member small employer is a valid small employer group and is not formed for the purpose of securing health benefits coverage. This assurance must include requirements that sole proprietors and self-employed individuals have been in business for a reasonable period of time as established by the Board, have provided filings to verify employment status, and have provided other evidence, in the Board's discretion, to ensure that the individual is working;

b. A member small employer who opts to pay seventy percent (70%) or more of the cost of coverage may choose to offer a single qualified health care plan to its eligible employees. Eligible employees of other member small employers shall have the choice of at least two qualified health care plans. All member small employers may offer the qualified health care plans of more than one Accountable Health Carrier. The Board and Alliances shall encourage all member small employers to consider offering more than one Accountable Health Carrier;

c. Minimum employer contribution requirements that shall be an amount not less than fifty percent (50%) of the premium for an employee's coverage of the lowest cost plan. The Alliance shall require that the employer contribute the same dollar amount for each employee regardless of the qualified health care plan chosen by the employee;

d. A mechanism that will provide for participation if an employer chooses not to participate but one hundred percent (100%) of the eligible employees who are not covered under a health benefit plan elect to purchase their coverage through the Alliance; and

e. Prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

(7) Ensure that any small employer or any employee of a small employer who meets the requirements established by the Board pursuant to subdivision (6) of this section may purchase health care coverage through an Alliance.

(8) Assure compliance with this Article by Alliances, small employers, and employee enrollees.

(9) Have the authority to request carrier information about the financial condition of the carrier consistent with the financial information required to be submitted by the carrier to the Department of Insurance.

(10) Assure fair and affirmative marketing of the qualified health care plans consistent with standards established by the Department of Insurance, the Small Employer Carrier Committee, and G.S. 143-632.

(11) Adopt rules in compliance with Chapter 150B of the General Statutes as necessary to administer the provisions of this Article.

(12) Appoint advisory committees that shall include persons with expertise in health benefits management and representatives of Accountable Health Carriers.

(13) Develop uniform standards for the data that Alliances collect from Accountable Health Carriers. In formulating such standards, the Board shall strive for consistency with health care data collection activities underway in North Carolina and nationally. Any data collection requirements promulgated by the Board shall be based on a study of their feasibility and cost-effectiveness, including their consistency with national standards for electronic data interchange, and their necessity for supporting the evaluation of Accountable Health Carriers and their provider networks with respect to cost containment, quality, control of expensive technology, and customer satisfaction. All enrollee satisfaction surveys employed by Alliances shall be in a standardized format promulgated by the Board.

(14) Have the authority to sue or be sued, including taking action necessary for securing legal remedies on behalf of, or against Alliances, member small employers, or employee enrollees and dependants of those employees.

(15) Have the authority to receive and accept grants or funds from any public or private agency and receive and accept contributions from any source of money, property, labor, or any other thing of value.

(16) Develop and implement standardized forms for use by Accountable Health Carriers in conformance with applicable national standards.

(17) Review, and limit if necessary, surcharges charged by each Alliance for administrative costs.

(18) Develop guidelines for any authorized marketing materials to be used in providing member small employers and their eligible employees with information regarding Accountable Health Carriers and their respective qualified health care plans in accordance with G.S. 143-632. Such guidelines shall be consistent with standards established by the Department of Insurance and the Small Employer Carrier Committee.

(19) Develop grievance procedures to be used in resolving disputes between member small employers and Alliances. A member small employer, Alliance or Accountable Health Carrier may appeal to the Board any grievance that is not resolved.

(20) Receive, review, and act on appeals of grievances not resolved.

(21) Analyze information collected from Accountable Health Carriers and other sources and report findings that assist consumers, Alliances, Accountable Health Carriers, or health care providers in improving the delivery or purchase of cost-effective health care.

(22) Report annually on the operation of the Board to the Joint Legislative Commission on Governmental Operations and the Governor.

"**§ 143-627. Alliances authorized.**

(a) The Board is authorized to create a single Alliance within each designated market area for the benefit of its member small employers. Each Alliance shall be operated as a State-chartered, nonprofit private organization.

(b) Each Alliance shall operate under the supervision of an Alliance Board of Directors, which shall consist of 11 members. The majority of members on each Alliance Board shall be small employers.

(1) The Board shall initially appoint six members for a term of two years. The community sponsor shall initially appoint five members for a term of two years. In so doing, the Board and community sponsor shall consider, among other things, whether all member small employers are fairly represented and assure that a majority of the Alliance Board shall be small employers.

(2) Subsequent members of the Alliance Board of Directors shall be elected pursuant to the Alliance Board's bylaws.

(c) Each Alliance Board shall adopt bylaws that shall include a procedure for the election of Alliance Board members by the Alliance's member small employers.

(d) Of the initially elected members of each Alliance Board, six members shall be designated to serve two-year terms and the remaining five members shall have four-year terms. Thereafter, the term of an elected member shall be four years.

(e) Vacancies on an Alliance Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members. A member to fill a vacancy may serve for the remainder of the term and until a qualified successor is elected for a new term.

(f) A member who serves two consecutive full four-year terms shall not be reelected for four years after completion of those terms.

(g) Members of the Alliance Board shall be bound by the financial interest restrictions set forth for Board members in G.S. 143-625(i) and (j).

(h) The Alliance Board shall elect officers from among its members every two years. Officers shall not serve more than two consecutive terms in an office.

(i) The Alliance Board shall meet at times and places as it determines necessary to operate the Alliance in accordance with this section and G.S. 143-628. Such meetings shall be governed by the procedures and polices set forth by the North Carolina Open Meetings Law, Article 33C of Chapter 143 of the General Statutes.

(j) There shall be no liability on the part of, and no cause of action of any nature shall arise against any member of the Alliance Board, or its employees or agents, for any action taken in good faith by them in the performance of their powers and duties as defined under G.S. 143-628.

(k) The Alliance Board shall have the powers and duties regarding operation of the Alliance set forth in G.S. 143-628.

"**§ 143-628. Powers and duties of the Health Plan Purchasing Alliance.**

An Alliance shall have the following powers and duties:

(1) Enter into contracts with Accountable Health Carriers for the provision of qualified health care plans for members of the Alliance pursuant to G.S. 143-629. Each Alliance shall contract with all Accountable Health Carriers which offer qualified health care plans operating in its market area and apply to serve member small employers;

(2) Enter into contracts with small employers pursuant to G.S. 143-630;

(3) Maintain eligibility records as appropriate to carry out the functions of this Article;

(4) Transmit enrollment and eligibility information to Accountable Health Carriers on a timely basis;

(5) Establish procedures for collection of premiums from member small employers, including the share of premiums paid by employee enrollees pursuant to G. S. 143-630;

(6) Pay contracted rates to Accountable Health Carriers on a monthly basis or as otherwise mutually agreed pursuant to G.S. 143-631;

(7) Impose annual surcharges established at the beginning of the fiscal year to be paid monthly by member small employers for necessary costs incurred in connection with the operation of the Alliance. The amount of annual surcharges shall cover any default on insurer premium payments by member small employer.

(8) Provide that in the event a member small employer terminates coverage purchased through the Alliance, the former member small employer shall be ineligible to purchase a qualified health care plan through the Alliance for a period of two years, except as permitted by the Alliance Board and the Board for good cause;

(9) Contract, as authorized by the Alliance Board of Directors, with a qualified third party for any service necessary to carry out the powers and duties as defined in this section, including contracts with agents to assist in contracting with Accountable Health Carriers and small employers and to assist the Alliance in undertaking activities necessary to administer the Alliance, such as marketing and publicizing the availability of the qualified health care plans;

(10) Provide to member small employers clear, standardized information on each Accountable Health Carrier and qualified health care plans offered by each Accountable Health Carrier, including information on price, enrollee costs, quality, patient satisfaction, enrollment, and enrollee responsibilities and obligations; and provide qualified health care plan comparison sheets in accordance with Board rules to be used in providing members and their employees with information regarding coverage that may be obtained through the Accountable Health Carriers;

(11) Appoint an executive director to serve as the chief operating officer of the Alliance, who may employ other staff as needed to administer the Alliance. The executive director shall serve at the pleasure of the Alliance Board;

(12) Establish advisory boards as necessary to assist with carrying out the duties established pursuant to this section;

(13) Establish administrative and accounting procedures for operating the Alliance, providing services to member small employers and employee enrollees, and preparing an annual budget;

(14) Prepare annual reports on the operations of the Alliance, including program and financial operations as required by the Board, and provide for annual internal and independent audits;

(15) Sue or be sued, including taking any legal actions necessary or proper for recovering any penalties for or on behalf of the Alliance;

(16) Maintain records and submit reports to the Board as required; and

(17) Accept and expend funds received through grants, appropriations, or other appropriate and lawful means.

"**§ 143-629. Accountable health carriers.**

(a) By July 1, 1994, the Board shall establish a process whereby a carrier that fulfills the qualifications of subsection (b) of this section shall be designated as an Accountable Health Carrier.

(b) In order to be eligible to be designated as an Accountable Health Carrier, a carrier must be able to demonstrate the following operating characteristics to the Board:

(1) Licensure and in good standing with the Department of Insurance;

(2) Capacity to administer the qualified health care plans;

(3) In the case of a carrier with a contractual obligation to provide or arrange for the covered health services, the ability to provide enrollees with adequate access to covered services within the carrier's service area;

(4) Grievance procedures, including the ability to respond to enrollees' calls, questions, and complaints;

(5) Established utilization management procedures;

(6) Ability to arrange and pay for the appropriate level and type of health care services;

(7) Ability to monitor and evaluate the quality and cost-effectiveness of care;

(8) Ability to assure enrollees with adequate numbers and types of health care providers;

(9) Ability to provide information on enrollee satisfaction based on standard surveys prescribed by the Board; and

(10) Ability to provide information on the types of treatments and outcomes with respect to the clinical health, functional status, and well-being of the enrollees based on standard data elements prescribed by the Board.

Carriers receiving accreditation by nationally recognized accreditation organizations, including, but not limited to, the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or qualification by federal agencies, shall be deemed to be in compliance with the requirements of subdivisions (2) through (10) of this subsection as they pertain to the relevant accreditation activities of the organization.

(c) After notice and hearing, the Board may suspend or revoke the designation as an Accountable Health Carrier of any carrier that fails to maintain compliance with the requirements listed in subsections (b), (d), or (e) of this section.

(d) Each Accountable Health Carrier shall:

(1) Offer qualified health care plans;

(2) Provide for the collection and reporting to the Board and to the appropriate Alliance of information on the performance of Accountable Health Carriers regarding the effectiveness and outcomes in providing selected services; provided, however, that data reporting requirements adopted by the Board shall be consistent with the method of operation of Accountable Health Carriers, shall be consistent with national standards where available, and shall not impose an unreasonable cost for compliance;

(3) Not deny, limit, or condition coverage under qualified health care plans based on health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability of an

eligible employee or dependent pursuant to the provisions of this Article;

(4) Establish premium rates for each qualified health care plan pursuant to the adjusted community rating method described in G.S. 58-50-130(b);

(5) Comply with all rules regarding rating, underwriting, claims handling, sales, solicitation, licensing, unfair trade practices and other provisions in this Article and Chapter 58 of the General Statutes.

(6) Issue a qualified health care plan to any member small employer that elects to be covered under a qualified health care plan offered by an Accountable Health Carrier during the open enrollment period established pursuant to subsection (e) of this section;

(7) Renew each qualified health care plan with respect to any member small employer except in the following cases:

a. Nonpayment of the required premiums;

b. Fraud or material misrepresentation of the member small employer, or the employee enrollee, or a dependent of the member small employer or the employee enrollee;

c. Noncompliance by a small employer with requirements regarding employer contribution or participation as required by the Board;

d. Repeated misuse of a provider network provision including, but not limited to, unreasonable refusal of the enrollee to follow a prescribed course of treatment, or violation of reasonable policies of an Accountable Health Carrier;

e. Election by the Accountable Health Carrier to terminate its contract with an Alliance. In such a case, the Accountable Health Carrier shall:

1. Provide advance notice of its decision in accordance with this sub-subdivision to the Alliance and to the Board;

2. Provide notice of the decision at least 180 days prior to the nonrenewal of any qualified health care plan to the enrollees. Except as provided in sub-subdivision f. of this subdivision an Accountable Health Carrier that elects not to renew a qualified health care plan with an Alliance shall be prohibited from writing new business with the Alliance for a period of three years from the date of notice to the Alliance or until the Alliance invites the carrier to renew participation, whichever is sooner; and

f. Determination by an Alliance, subject to review by the Board, that continuation of coverage would not be in the best interest of the employee enrollees and member small employers or would impair the Accountable Health Carrier's ability to meet its contractual obligations. In this instance, the Alliance shall assist affected employee enrollees in finding replacement coverage;

(8) Provide a procedure for addressing grievances that arise between the Accountable Health Carrier and the Alliance, member small employers, or employee enrollees; and

(e) Each Accountable Health Carrier shall offer an open enrollment period to small employers at the anniversary date of the member small employers' qualified health care plan. The open enrollment period shall be at least 30 consecutive calendar days. Member small employers may choose from the Accountable Health Carriers selected from the qualified health care plans that are offered in the market area in which they reside. An Accountable Health Carrier shall not be required to offer coverage or accept enrollments if:

(1) The eligible employee or dependent does not reside within the Accountable Health Carrier's approved service area;

(2) An Accountable Health Carrier provides 90 days' prior notice that it will not have the capacity to deliver service adequately in a market area to additional enrollees because of its obligations to existing groups and enrollees; or

(3) The Commissioner of Insurance determines that the acceptance of an application or applications would place an Accountable Health Carrier in a financially impaired condition.

(f) An Accountable Health Carrier that cannot offer coverage pursuant to subdivision (2) of subsection (e) of this section shall not offer coverage to or accept applications from a new employer group or an individual until the later of 90 days following such refusal or the date on which the Accountable Health Carrier notifies the Alliance and the Board that it has regained capacity to deliver services to eligible employees and their dependents in the service area. An Accountable Health Carrier that cannot offer coverage pursuant to subdivision (3) of subsection (e) of this section shall not offer coverage or accept applications for any individual or employer group until a determination by the Commissioner of Insurance that acceptance of an application will not put the Accountable Health Carrier in a financially impaired condition.

(g) Nothing in this Article or any other provision of the General Statutes shall prohibit an Accountable Health Carrier from providing a qualified health care plan in an Alliance through a managed-care system, and from contracting with particular health care providers or types, classes, or categories of health care providers.

"§ 143-630. Payment to Alliance by member small employers.

The contracts between Alliances and member small employers and between Accountable Health Carriers and Alliances shall provide that payment of all premiums shall be transmitted by member small employers on their behalf and on behalf of the employee enrollee, directly to the Alliance for the benefit of the Accountable Health Carrier. Premiums shall be payable on a monthly basis. Alliances may provide for penalties and grace periods for late payment. Nonpayment of premiums by a member small employer or employee enrollee shall constitute a breach of contract and a breach of the insurance policy.

"§ 143-631. Payment by Alliance to Accountable Health Carriers.

(a) Under a contract between an Accountable Health Carrier and an Alliance, the Alliance shall forward to each Accountable Health Carrier with enrollees under a qualified health care plan an amount equal to:

(1) Premiums determined by the Accountable Health Carrier's contracted rates; and

(2) Adjustments in payments, if any, resulting from a risk adjustment mechanism determined in accordance with G.S. 143-633.

(b) The Alliances shall pay the Accountable Health Carrier on a monthly basis.

"§ 143-632. Marketing qualified health care plans.

(a) Each Alliance shall use efficient and standardized means to notify small employers of the availability of sponsored health coverage through the Alliance.

(b) Each Alliance shall make available to member small employers marketing materials accurately summarizing the benefit plans, rates, cost, and accreditation information that its Accountable Health Carriers offer through the Alliance.

(c) If authorized by the Board, an Accountable Health Carrier may provide, directly or through an agent, broker, or contractor, marketing material relating to health plans offered through the Alliance. Accountable Health Carriers shall not need authorization from an Alliance for advertisement to the public at large through the means of mass media.

(d) Nothing in this section shall be construed to or explicitly prohibit an Alliance or Accountable Health Carrier from using the services of an agent or broker in order to assist in marketing. An Accountable Health Carrier shall not vary compensation or commissions to such agents or brokers based, directly or indirectly, on the anticipated or actual claims experience or health status associated with particular small employers to which each plan is sold.

(e) No Accountable Health Carrier, agent of an Accountable Health Carrier or independent insurance agent shall engage, directly or indirectly, in any activity of marketing practices that would encourage member small employers or eligible employees to:

(1) Refrain from enrolling in the Accountable Health Carrier because of their health status or claim experience; or

(2) Seek coverage from other Accountable Health Carriers because of their health status or claim experience.

(f) An Alliance shall notify the Board of any marketing practices or materials that it finds contrary to the fair and affirmative marketing requirements of this Article. Furthermore, the Board shall monitor compliance with this section, including the conduct of Accountable Health Carriers and their agents, brokers, or contractors, and shall report to the Department of Insurance any unfair trade practices and misleading or unfair conduct that has been reported to the Board by Alliances, agents, consumers, or any other individual. The Department of Insurance shall investigate all reports and, upon a finding of noncompliance with this section or of unfair and misleading practices, shall take action against violators as permitted under Chapter 58 of the General Statutes or this Article. The Board shall forward all reports of cases or abuse to the Department of Insurance for investigation.

"**§ 143-633. Risk adjustment mechanism.**

(a) The Board shall establish a payment mechanism to adjust for the amount of risk covered by each qualified health care plan offered by an Accountable Health Carrier. Risk adjustment shall be based on prospectively determined factors that predict utilization of health care services.

(b) On an annual basis, the Board shall establish a factor that represents the difference between the average risk of persons covered through the Alliance and the risk covered by each qualified health care plan offered by each Accountable Health Carrier through the Alliance. The Board shall apply that factor in determining amounts received by Accountable Health Carriers. This may be done directly or it may be done indirectly by adjusting quoted premiums. The mechanism by which the adjustment is made shall be established after consultation with a technical advisory committee.

(c) In addition to the risk adjustment mechanism described in subsections (a) and (b) of this section, the Board may develop a list of a limited number of high cost diagnoses. The Board may develop a mechanism to protect an Accountable Health Carrier that has a disproportionate share of one or more of the listed diagnoses.

(d) Any payments to Accountable Health Carriers under this section shall be determined on an annual basis. No payments under this section shall be based on claims or the health care costs of an Accountable Health Carrier.

"§ 143-634. Antitrust protection.

In addition to the duties described in G.S. 143-626, the Board shall actively supervise the Alliances to ensure that actions affecting market competition are not for private interests, but accomplish the legislative intent of this Article. The Board shall also monitor conduct throughout the small employer market to ensure that the legislative intent of this Article to improve the competitiveness of the small employer health coverage market is not impeded.

"§ 143-635. State Health Plan Purchasing Alliance Fund.

(a) There is established in the Office of the State Treasurer, the State Health Plan Purchasing Alliance Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund shall be spent only in accordance with subsection (b) of this section. The Fund shall be administered in accordance with the Executive Budget Act.

(b) All money credited to the Fund shall be used as set forth by the Board.

(c) Moneys appropriated by the General Assembly shall be deposited in the Fund and shall become part of the continuation budget of the Department of Administration.

"§ 143-636. Continuation and conversion of coverage.

(a) For member small employers not covered by Subtitle B of Title III, Public Law 100-647 (26 U.S.C. § 4980B), enrollees who lose their health care coverage due to loss of employment shall be offered the option of continuing health care coverage for one year, provided such enrollee pays the entire required premium charged to the enrollee's former employer and remains a resident of the State. An enrollee shall transmit payment of premium payments through the enrollee's former employer, who shall submit it to the respective Alliance.

(b) At the end of one year of continuation coverage, such enrollees shall be offered a conversion option if such option, where available, is available for former group enrollees."

Sec. 3.2. G.S. 58-50-130(b) reads as rewritten:

"(b) Premium rates for health benefit plans subject to this Act are subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than ~~twenty-five percent (25%)~~, twelve and one-half percent (12.5%), adjusted pro rata for any rating period of less than one year.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the index rate by more than ~~thirty-five percent (35%)~~ twenty-five percent (25%) of the index rate, adjusted pro rata for any rating period of less than one year.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one year, may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing

policies, the carrier shall use the percentage change in the base premium rate.

b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

c. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.

(6) In any case where a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than ~~fifteen percent (15%)~~ seven and one-half percent (7 ½%) of coverage.

(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate.

b. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer."

Sec. 3.3. G.S. 58-50-110, as amended by Chapter 408 of the 1993 Session Laws, reads as rewritten:

"**§ 58-50-110. Definitions.**

As used in this Act:

(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1a) 'Accountable Health Carrier' means that as defined in G.S. 143-622(1).

(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

~~(2) 'Base premium rate' means for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.~~

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

~~(6) 'Case characteristics' means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer; but does not mean claim experience, health status, and duration of coverage since issue.~~

~~(7) 'Class of business' means all or a distinct grouping of small employers as shown on the records of a small employer carrier.~~

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service

corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

~~(13) 'Index rate' means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.~~

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The ~~individual:~~

~~1.~~ ~~Was~~ individual was covered under ~~another employer~~ a public or private health benefit plan that provided, at the time the individual was eligible to ~~enroll;~~ enroll, the same required level of benefits in the basic and standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a basic or standard health care plan within 30 days after termination of coverage provided under another health plan; or

2. Stated, ~~at the time of the initial enrollment,~~ in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining ~~enrollment;~~ coverage;

~~3. Has lost coverage under another employer health benefit plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and~~

~~4. Requests enrollment within 30 days after termination of coverage provided under another employer health benefit plan;~~

~~b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or~~

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

~~c.~~d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court ~~order.~~ order; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of the individual or employee's marriage or the birth or adoption of a child.

~~(15) 'New business premium rate' means, for each class of business as to a rating period, the lowest premium rate charged, offered, or that could have been charged by a small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.~~

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) 'Small employer' means any ~~person~~ individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding ~~year,~~ calendar quarter, employed no more than 49 eligible ~~employees and not less than two eligible employees,~~ employees, the majority of whom are employed within this ~~State.~~ State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. ~~Small employer includes companies that are affiliated companies, as defined in G.S. 58-19-5(1) or that are eligible to file a combined tax return under Chapter 105 of the General Statutes or under the Internal Revenue Code.~~ In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this ~~section.~~ definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Sec. 3.4. G.S. 58-50-113 is repealed.

Sec. 3.5. G.S. 58-50-115 reads as rewritten:

"**§ 58-50-115. Health benefit plans subject to Act.**

~~(a)~~ A health benefit plan is subject to this Act if it provides health benefits for small employers or self-employed individuals and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium; ~~or for which the small employer has permitted payroll deduction for the covered individual, whether or not the coverage is issued through a group or individual policy of insurance, and whether or not the small employer pays any part of the premium.~~

(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purpose of ~~section 162 or section 106~~ sections 106, 125, or 162 of the United States Internal Revenue ~~Code.~~ Code; or

(3) The small employer or self-employed individuals have permitted payroll deductions for the eligible enrollees for the health benefit plans.

~~(b) The provisions of G.S. 58-51-95(f) do not apply to individual accident and health insurance policies or contracts to the extent subject to the provisions of this Act.~~"

Sec. 3.6. G.S. 58-50-125 reads as rewritten:

"§ 58-50-125. Health care plans; formation; approval; offerings.

(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Notwithstanding subsection (c) of this section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions.

(b) After the Commissioner's approval of the plans submitted by the Committee under subsection (a) of this section and in lieu of any contrary procedure established by this Chapter, any small employer carrier may certify to the Commissioner, in the form and manner prescribed by the Commissioner, that the basic and standard health care plans filed by the carrier are in substantial compliance with the provisions of the corresponding approved Committee plans. Upon receipt by the Commissioner of the certification, the carrier may use the certified plans unless their use is disapproved by the Commissioner.

(c) The plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider.

(d) Within 180 days after the Commissioner's approval under subsection (b) of this section, every small employer carrier shall, as a condition of transacting business in this State, offer small employers at least one basic and one standard health care plan. Every small employer that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of small employers that elect coverage in accordance with this subsection by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain

diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer.

(e) No small employer carrier is required to offer coverage or accept applications under subsection (d) of this section:

(1) From a group already covered under a health benefit plan except for coverage that is to begin after the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group before its anniversary date; or

(2) If the Commissioner determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer. ~~insurer; or~~

~~(3) To groups of fewer than five eligible employees where the small employer carrier does not use preexisting conditions provisions in all health benefit plans it issues to any small employers.~~

~~If a small employer carrier who does not use preexisting conditions chooses to market to groups of less than five, then it shall immediately notify the Commissioner and the Board, and it shall do so consistently and equally to all such small employer groups.~~

(f) Every small employer carrier shall fairly market the basic and standard health care plan to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits.

(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a ~~group, where the~~ group that is not physically located in the HMO's approved service areas;

(2) To an ~~employee, where the~~ employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably ~~anticipates,~~ anticipate, and ~~demonstrates~~ demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than ~~25~~ 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers.

(h) The provisions of subsections (b), (d), and (g) and subdivision (e)(2) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

Sec. 3.7. G.S. 58-50-130, as rewritten by Section 3.2 of this act and by Section 6 of Chapter 408 of the 1993 Session Laws, reads as rewritten:

"**§ 58-50-130. Required health care plan provisions.**

"(a) Health benefit plans covering small employers are subject to the following provisions:

(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as 'those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage'.

(2) In determining whether a preexisting-conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:

a. For nonpayment of the required premiums by the policyholder or contract holder;

b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;

c. For noncompliance with plan provisions that have been approved by the Commissioner;

d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or

e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

f. When the small employer carrier stops writing new business in the small employer market, if:

1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and

2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.

A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the

HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.

(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer.

~~(5) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group, and the minimum participation for a small employer group must be the greater of two or twenty-five percent (25%) of eligible employees. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met. 'Qualifying existing coverage' means benefits or coverage provided under: (i) Medicare or Medicaid; or (ii) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health care plan.~~

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary of an insurer, or controlled individual of a holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of a holding company shall provide stop loss, catastrophic, or reinsurance coverage to small groups which, if they were purchased, would be subject to this section.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

(7) A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan

currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.

~~(b) Premium rates for health benefit plans subject to this Act are subject to the following provisions:~~

~~(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twelve and one half percent (12.5%), adjusted pro rata for any rating period of less than one year.~~

~~(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the index rate by more than twenty five percent (25%) of the index rate, adjusted pro rata for any rating period of less than one year.~~

~~(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one year, may not exceed the sum of the following:~~

~~a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate.~~

~~b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

~~c. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

~~(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.~~

~~(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.~~

~~(6) In any case where a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than seven and one half percent (7.5%) of coverage.~~

~~(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. In that case, the percentage increase in~~

~~the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:~~

~~a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate.~~

~~b. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.~~

~~(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer.~~

(b) For all small employer health benefit plans that are subject to this section and are issued on or after January 1, 1995, premium rates for health benefit plans subject to this section are subject to the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary on the basis of the eligible employee's or dependent's age as determined in accordance with subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection;

(2) Rating factors related to age, gender, number of family members covered, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review;

(3) Small employer carriers shall not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changed by twenty percent (20%) or more or benefits are changed;

(4) Carriers participating in an Alliance in accordance with the Health Care Purchasing Alliance Act may apply a different community rate to business written in that Alliance;

(5) In the case of health benefit plans issued before January 1, 1995, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may vary from the adjusted community rating index line, as determined by the small employer carrier and in accordance with subdivisions (1), (2), (3), and (4) of this subsection, for a period of two years after January 1, 1995, as follows:

a. On January 1, 1995, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the adjusted community rate by more than twenty percent

(20%) of the index rate, adjusted pro rata for any rating period of less than one year;

b. On January 1, 1996, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the adjusted community rate by more than ten percent (10%) of the index rate, adjusted pro rata for any rating period of less than one year; and

c. On January 1, 1997, all small employer benefit plans that are subject to this section and are issued by small employer carriers before January 1, 1997, and that are renewed on or after January 1, 1997, renewal rates shall be based on the same adjusted community rating standard applied to new business.

(6) For the purposes of subsection (b) of this section, a small employer carrier shall not use age brackets of less than five years;

(7) For the purposes of subsection (b) of this section, a carrier shall not apply different geographic rating factors to the rates of small employers located within the same county; and

(8) The Department of Insurance may, by rule, establish regulations to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those regulations shall include consideration of differences based on the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs;

b. Except as provided for in sub-subdivision a. above, differences in premium rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates due to the demographics of groups assumed to select particular health benefit plans; and

c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers. Adjustments in rates for age, gender, and geography shall not be applied individually. Any such adjustment shall be applied uniformly to the rate charged for all employee enrollees of the small employer.

~~(c) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the carrier offers to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since issue.~~

(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

~~(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or~~

~~expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of the small employer.~~

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1, 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

Sec. 3.8. G.S. 58-53-35 reads as rewritten:

"**§ 58-53-35. Termination of continuation.**

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date ~~three months~~ one year after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participating under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have been terminated. The insurer that insured the group prior to the date of

termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled."

Sec. 3.9. G.S. 120-123 is amended by adding a new subdivision to read:

"(61) The State Health Plan Purchasing Alliance Board, as established by G.S. 143-625."

Sec. 3.10. The State Health Plan Purchasing Alliance Board shall report not later than January 1, 1995, to the Joint Legislative Commission on Governmental Operations on the following:

(1) The progress achieved in expanding the availability of affordable insurance to employees of small employers;
(2) Employee choice;
(3) The possible need for financial incentives to encourage increased participation;
(4) The demographic factors used to determine the adjusted community rating method;
(5) The possible need to have exclusive purchasing of health insurance through the Alliance for all small employers who choose to purchase health insurance;
(6) Options for including (i) employers with more than 50 employees, and (ii) populations from State and federally financed systems of health coverage;
(7) The need for federal waivers;
(8) Developments in health care reform at the federal level as well as in other states, including, but not limited to, Florida and other states in the southeast region of the United States; and
(9) The need to develop, to the extent feasible and consistent with national standards, standard information to be collected from Accountable Health Carriers on the types of treatments and outcomes with respect to the clinical health, functional status, and well-being of enrollees.

Sec. 3.11. Within 30 days of ratification of this act, the Governor, the General Assembly upon the recommendation of the Speaker of the House of Representatives, and the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall make their appointments to the State Health Care Purchasing Alliance Board. Those appointments restricted by G.S. 143-625(b) shall be drawn from among persons who own, manage, or are employed by a small employer as defined in G.S. 143-622 who would qualify as a member small employer under this act. If initial appointments are not made by the General Assembly prior to August 1, 1993, those positions shall be filled by appointment pursuant to G.S. 120-122.

Sec. 3.12. Of the funds appropriated to the Reserve for Health Care Initiatives in Chapter 321 of the 1993 Session Laws, the sum of four million dollars ($4,000,000) for the 1993-94 fiscal year and the sum of five hundred thousand dollars ($500,000) for the 1994-95 fiscal year shall be used for the initial operation of the Health Care Purchasing Alliance Board and other activities related to the duties and responsibilities of the Alliances and the State Health Purchasing Alliance Board authorized by Section 3.1 of this act.

Sec. 3.13. Section 3.2 of this act becomes effective January 1, 1994. Sections 3.3 through 3.7 of this act become effective January 1, 1995. Alliances shall

become operational on or after January 1, 1995. The remainder of this Part is effective upon ratification.

PART IV.--UNIFORM CLAIM FORMS

Sec. 4.1. G.S. 58-50-10 is repealed.

Sec. 4.2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-3-171. Uniform claim forms.**

(a) All claims submitted by health care providers to health benefit plans shall be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner. Additional information beyond that contained on the uniform form or format may be collected subject to rules adopted by the Commissioner. This section applies to the submission of claims in writing and by electronic means.

(b) After consultation with the North Carolina Industrial Commission, the Commissioner may include workers' compensation insurance policies as 'health benefit plans' for the purpose of administering the provisions of this section.

(c) For purposes of this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health maintenance organization (HMO) subscriber contracts and other plans provided by managed-care organizations; plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; the Teachers' and State Employees' Comprehensive Major Medical Plan; and medical payment coverages under homeowners and automobile insurance policies.

"**§ 58-3-172. Notice of claim denied.**

(a) For all claims denied for heath care provider services under health benefit plans, written notification of the denied claim shall be given to the insured and to the health care provider submitting the claim if the health care provider would otherwise be eligible for payment.

(b) For purposes of this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts and other plans provided by managed-care organizations; plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; and the Teachers' and State Employees' Comprehensive Major Medical Plan."

Sec. 4.3. Chapter 90 of the General Statutes is amended by adding a new Article 28 to read:

"ARTICLE 28.
"Medical Records.

"**§ 90-410. Definitions.**

As used in this Article:

(1) 'Health care provider' means any person who is licensed or certified to practice a health profession or occupation under this Chapter or Chapters 90B or 90C of the General Statutes, a health care facility licensed under Chapters 131E or 122C of the General Statutes, and a representative or agent of a health care provider.

(2) 'Medical records' means personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, excluding X rays and fetal monitor records.

"**§ 90-411. Record copy fee.**

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee shall be fifty cents (50c) per page, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. This section shall only apply with respect to liability claims for personal injury."

Sec. 4.4. This Part becomes effective January 1, 1994.

PART V.--HOSPITAL COOPERATION

Sec. 5.1. Part V of this act shall be known as the Hospital Cooperation Act of 1993.

Sec. 5.2. Chapter 131E of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 9A.

"Certificate of Public Advantage.

"**§ 131E-192.1. Findings.**

The General Assembly of North Carolina makes the following findings:

(1) That technological and scientific developments in hospital care have enhanced the prospects for further improvement in the quality of care provided by North Carolina hospitals to North Carolina citizens.

(2) That the cost of improved technology and improved scientific methods for the provision of hospital care contributes substantially to the increasing cost of hospital care. Cost increases make it increasingly difficult for hospitals in rural areas of North Carolina to offer care.

(3) That changes in federal and State regulations governing hospital operation and reimbursement have constrained the ability of hospitals to acquire and develop new and improved machinery and methods for the provision of hospital-related care.

(4) That cooperative agreements among hospitals and between hospitals and others for the provision of health care services may foster improvements in the quality of health care for North Carolina citizens, moderate increases in cost, improve access to needed services in rural areas of North Carolina, and enhance the likelihood that smaller hospitals in North Carolina will remain open in beneficial service to their communities.

(5) That hospitals are often in the best position to identify and structure cooperative arrangements that enhance quality of care, improve access, and achieve cost-efficiency in the provision of care.

(6) That federal and State antitrust laws may prohibit or discourage cooperative arrangements that are beneficial to North Carolina citizens despite their potential for or actual reduction in competition and that such agreements should be permitted and encouraged.

(7) That competition as currently mandated by federal and State antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals,

or between hospitals and others, that are beneficial to North Carolina citizens when the benefits of cooperative agreements outweigh their disadvantages caused by their potential or actual adverse effects on competition.

(8) That regulatory as well as judicial oversight of cooperative agreements should be provided to ensure that the benefits of cooperative agreements permitted and encouraged in North Carolina outweigh any disadvantages attributable to any reduction in competition likely to result from the agreements.

"§ 131E-192.2. Definitions.

The following definitions apply in this Article:

(1) 'Attorney General' means the Attorney General of the State of North Carolina or any attorney on his or her staff to whom the Attorney General delegates authority and responsibility to act pursuant to this Article.

(2) 'Cooperative agreement' means an agreement among two or more hospitals, or between a hospital and any other person, for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities, or medical, diagnostic, or laboratory facilities or equipment, or procedures or other services traditionally offered by hospitals. Cooperative agreement shall not include any agreement by which ownership over substantially all of the stock, assets, or activities of one or more previously licensed and operating hospitals is transferred nor any agreement that would permit self-referrals of patients by a health care provider that is otherwise prohibited by law.

(3) 'Department' means the Department of Human Resources.

(4) 'Hospital' means any hospital required to be licensed under Chapters 131E or 122C of the General Statutes.

(5) 'Person' means any individual, firm, partnership, corporation, association, public or private institution, political subdivision, or government agency.

(6) 'Federal or State antitrust laws' means any and all federal or State laws prohibiting monopolies or agreements in restraint of trade, including the federal Sherman Act, Clayton Act, Federal Trade Commission Act, and North Carolina laws codified in Chapter 75 of the General Statutes that prohibit restraints on competition.

"§ 131E-192.3. Certificate of public advantage; application.

(a) A hospital and any person who is a party to a cooperative agreement with a hospital may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any State antitrust law if a certificate of public advantage is issued for the cooperative agreement, or in the case of activities to negotiate or enter into a cooperative agreement, if an application for a certificate of public advantage is filed in good faith. It is the intention of the General Assembly that immunity from federal antitrust laws shall also be conferred by this statute and the State regulatory program that it establishes.

(b) Parties to a cooperative agreement may apply to the Department for a certificate of public advantage governing that cooperative agreement. The application must include an executed written copy of the cooperative agreement or letter of intent with respect to the agreement, a description of the nature and scope of the activities and cooperation in the agreement, any consideration passing to any

party under the agreement, and any additional materials necessary to fully explain the agreement and its likely effects. A copy of the application and all additional related materials shall be submitted to the Attorney General at the same time the application is submitted to the Department.

"**§ 131E-192.4. Procedure for review; standards for review.**

(a) The Department shall review an application in accordance with the standards set forth in subsection (b) of this section and shall hold a public hearing with the opportunity for the submission of oral and written public comments in accordance with rules adopted by the Department. The Department shall determine whether the application should be granted or denied within 90 days of the date the application is filed. The Department may extend the review period for a specified period of time upon notice to the parties.

(b) The Department shall determine that a certificate of public advantage should be issued for a cooperative agreement if it determines that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement outweigh the disadvantages likely to result from a reduction in competition from the agreement.

In evaluating the potential benefits of a cooperative agreement, the Department shall consider whether one or more of the following benefits may result from the cooperative agreement:

(1) Enhancement of the quality of hospital and hospital-related care provided to North Carolina citizens.

(2) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.

(3) Lower costs of, or gains in, the efficiency of delivering hospital services.

(4) Improvements in the utilization of hospital resources and equipment.

(5) Avoidance of duplication of hospital resources.

(6) The extent to which medically underserved populations are expected to utilize the proposed services.

In evaluating the potential disadvantages of a cooperative agreement, the Department shall consider whether one or more of the following disadvantages may result from the cooperative agreements:

(1) The extent to which the agreement may increase the costs or prices of health care at a hospital which is party to the cooperative agreement.

(2) The extent to which the agreement may have an adverse impact on patients in the quality, availability, and price of health care services.

(3) The extent to which the agreement may reduce competition among the parties to the agreement and the likely effects thereof.

(4) The extent to which the agreement may have an adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payors to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers.

(5) The extent to which the agreement may result in a reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals.

(6) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition.

In making its determination, the Department may consider other benefits or disadvantages that may be identified.

"**§ 131E-192.5. Issuance of a certificate.**

If the Department determines that the likely benefits of a cooperative agreement outweigh the likely disadvantages attributable to reduction of competition as a result of the agreement by clear and convincing evidence, and the Attorney General has not stated any objection to issuance of a certificate during the review period, the Department shall issue a certificate of public advantage for the cooperative agreement at the conclusion of the review period. The certificate shall include any conditions of operation under the agreement that the Department, in consultation with the Attorney General, determines to be appropriate in order to ensure that the cooperative agreement and the activities engaged under it are consistent with this Article and its purpose to limit health care costs. The Department shall include conditions to control prices of health care services provided under the cooperative agreement. Consideration shall be given to assure that access to health care is provided to all areas of the State. The Department shall publish its decisions on applications for certificates of public advantage in the North Carolina Register.

"**§ 131E-192.6. Objection by Attorney General.**

If the Attorney General is not persuaded that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement outweigh the likely disadvantages of any reduction of competition to result from the agreement as set forth in G.S. 131E-192.4, the Attorney General may, within the review period, state an objection to the issuance of a certificate of public advantage and may extend the review period for a specified period of time. Notice of the objection and any extension of the review period shall be provided in writing to the applicant, together with a general explanation of the concerns of the Attorney General. The parties may attempt to reach an agreement with the Attorney General on modifications to the agreement or to conditions in the certificate so that the Attorney General no longer objects to issuance of a certificate. If the Attorney General withdraws the objection and the Department maintains its determination that a certificate should be issued, the Department shall issue a certificate of public advantage with any appropriate conditions as soon as practicable following the withdrawal of the objection. If the Attorney General does not withdraw the objection, a certificate shall not be issued.

"**§ 131E-192.7. Record keeping.**

The Department shall maintain on file all cooperative agreements for which certificates of public advantage are in effect and a copy of the certificate, including any conditions imposed in it. Any party to a cooperative agreement who terminates an agreement shall file a notice of termination with the Department within 30 days after termination. These files shall be public records as set forth in Chapter 132 of the General Statutes.

"**§ 131E-192.8. Review after issuance of certificate.**

If at any time following the issuance of a certificate of public advantage, the Department or the Attorney General has questions concerning whether the parties to the cooperative agreement have complied with any condition of the certificate or whether the benefits or likely benefits resulting from a cooperative agreement may no longer outweigh the disadvantages or likely disadvantages attributable to a reduction in competition resulting from the agreement, the Department or the Attorney General shall advise the parties to the agreement, and either the Department or the

Attorney General shall request any information necessary to complete a review of the matter.

"§ 131E-192.9. Periodic reports.

(a) During the time that a certificate is in effect, a report of activities pursuant to the cooperative agreement must be filed every two years with the Department on or before the anniversary date on which the certificate was issued. A copy of the periodic report shall be submitted to the Attorney General at the same time that it is filed with the Department. A report shall include all of the following:

(1) A description of the activities conducted pursuant to the agreement.

(2) Price and cost information.

(3) The nature and scope of the activities pursuant to the agreement anticipated for the next two years, the likely effect of those activities.

(4) A signed certificate by each party to the agreement that the benefits or likely benefits of the cooperative agreement as conditioned continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement as conditioned.

(5) Any additional information requested by the Department or the Attorney General.

The Department shall give public notice in the North Carolina Register that a report has been received. After notice is given, the public shall have 30 days to file written comments on the report and on the benefits and disadvantages of continuing the certificate of public advantage. Periodic reports, public comments, and information submitted in response to a request shall be public records as set forth in Chapter 132 of the General Statutes.

(b) Failure to file a periodic report required by this section after notice of default or failure to provide information requested pursuant to a review under G.S. 131E-192.8 is grounds for the revocation of the certificate by the Attorney General or the Department.

(c) The Department shall review each periodic report, public comments, and information submitted in response to a request under G.S. 131E-192.8 to determine whether the advantages or likely advantages of the cooperative agreement continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement, and to determine what, if any, changes in the conditions of the certificate should be made. In the review the Department shall consider the benefits and disadvantages set forth in G.S. 131E-192.4. Within 60 days of the filing of a periodic report, the Department shall determine whether the certificate should remain in effect and whether any changes to the conditions in the certificate should be made. The Department may extend the review period an additional 30 days. If either the Department or the Attorney General determines that the parties to a cooperative agreement have not complied with any condition of the certificate, the Department or the Attorney General shall revoke the certificate and the parties shall be notified. If the certificate is revoked, the parties shall be entitled to no benefits under this Article, beginning on the date of revocation. If the Department determines that the certificate should remain in effect and the Attorney General has not stated any objection to the certificate remaining in effect during the review period, the certificate shall remain in effect subject to any changes in the conditions of the certificate imposed by the Department. The parties shall be notified in writing of the Department's decision and of any changes in the conditions of the certificate. The Department shall publish its decision and any changes in the conditions in the North Carolina Register.

If the Department determines that the benefits or likely benefits of the agreement and the unavoidable costs of terminating the agreement do not continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement, or if the Attorney General objects to the certificate remaining in effect based upon a review of the benefits and disadvantages set forth in G.S. 131E-192.4, the Department shall notify the parties to the agreement in writing of its determination or the objections of the Attorney General and shall provide a summary of any concerns of the Department or Attorney General to the parties.

"**§ 131E-192.10. Right to judicial action.**

(a) Any applicant or other person aggrieved by a decision to issue or not issue a certificate of public advantage is entitled to judicial review of the action or inaction in superior court. Suit for judicial review under this subsection shall be filed within 30 days of public notice of the decision to issue or deny issuance of the certificate. To prevail in any action for judicial review brought under this subsection, the plaintiff or petitioner must establish that the determination by the Department or the Attorney General was arbitrary or capricious.

(b) Any party or other person aggrieved by a decision to allow a certificate to remain in effect or to make changes in the conditions of a certificate is entitled to judicial review of the decision in superior court. Suit for judicial review under this subsection shall be filed within 30 days of public notice of the decision to allow the certificate to remain in effect or to make changes in the conditions of the certificate. To prevail in any action for judicial review brought under this subsection, the plaintiff or petitioner must establish that the determination by the Department or the Attorney General was arbitrary or capricious.

(c) If the Department or the Attorney General determines that the certificate should not remain in effect, the Attorney General may bring suit in the Superior Court of Wake County on behalf of the Department, or on its own behalf, to seek an order to authorize the cancellation of the certificate. To prevail in the action, the Attorney General must establish that the benefits resulting from the agreement are outweighed by the disadvantages attributable to a reduction in competition resulting from the agreement.

(d) In any action instituted under this section, the work product of the Department, the Attorney General or his staff, is not a public record under Chapter 132, and shall not be discoverable or admissable, nor shall the Attorney General or any member of his staff be compelled to be a witness, whether in discovery or at any hearing or trial.

"**§ 131E-192.11. Fees for applications and periodic reports.**

The Department and the Attorney General shall establish a schedule of fees for filing an application for a certificate of public advantage and for filing a periodic report based on the total cost of the project for which the application or periodic report is made. The fee for filing an application may not exceed fifteen thousand dollars ($15,000). The fee for filing a periodic report may not exceed two thousand five hundred dollars ($2,500). The fee schedule established should generate sufficient revenue to offset the costs of the program. An application filing fee must be paid to the Department at the time an application for a certificate of public advantage is submitted to it pursuant to G.S. 131E-192.3. A periodic report filing fee must be paid to the Department at the time a periodic report is submitted to it pursuant to G.S. 131E-192.9.

"**§ 131E-192.12. Department and Attorney General authority.**

The Department and Attorney General shall have the necessary powers to adopt rules to conduct a review of applications for certificates of public advantage and of periodic reports filed in connection therewith and to bring actions in the Superior

Court of Wake County as required under G.S. 131E-192.10. This Article shall not limit the authority of the Attorney General under federal or State antitrust laws.

"§ 131E-192.13. Effects of certificate of public advantage; other laws.

(a) Activities conducted pursuant to a cooperative agreement for which a certificate of public advantage has been issued are immunized from challenge or scrutiny under State antitrust laws. In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is filed in good faith shall be immune from challenge or scrutiny under State antitrust laws, regardless of whether a certificate is issued. It is the intention of the General Assembly that this Article shall also immunize covered activities from challenge or scrutiny under federal antitrust law.

(b) Nothing in this Article shall exempt hospitals or other health care providers from compliance with State or federal laws governing certificate of need, licensure, or other regulatory requirements.

(c) Any dispute among the parties to a cooperative agreement concerning its meaning or terms is governed by normal principles of contract law."

Sec. 5.3. G.S. 131E-7(b) reads as rewritten:

"(b) ~~A municipality may contract with or otherwise arrange with other municipalities of this or other states, federal or public agencies or with any person, private organization or nonprofit association for the provision of hospital, clinical, or similar services. The municipality may pay for these services from appropriations or other moneys available for these purposes.~~ A municipality or a public hospital may contract with or enter into any arrangement with other public hospitals or municipalities of this or other states, the State of North Carolina, federal, or public agencies, or with any person, private organization, or nonprofit corporation or association for the provision of health care. The municipality or public hospital may pay for or contribute its share of the cost of any such contract or arrangement from revenues available for these purposes, including revenues rising from the provision of health care."

Sec. 5.4. The Department of Human Resources and the Attorney General shall prepare and submit a report to the 1999 General Assembly summarizing and analyzing the effects of this Part. The report shall include the results of efforts to assure access to health care and to control increases in health care costs and any recommendations the Department may have for amendments to this Part.

Sec. 5.5. Sections 5.1, 5.2, and 5.4 are effective upon ratification. Section 5.3 becomes effective October 1, 1993.

PART VI.--HOSPITAL AUTHORITY TERRITORY

Sec. 6.1. G.S. 131E-20(a) reads as rewritten:

"(a) The territorial boundaries of a hospital authority shall include the city or county creating the authority and the area within 10 miles from the territorial boundaries of that city or county. However, a hospital authority may engage in health care activities in a county outside its territorial boundaries pursuant to:

(1) An agreement with a hospital facility if only one hospital currently exists in that county;

(2) An agreement with any hospital if more than one hospital currently exists in that county; or

(3) An agreement with any health care agency if no hospital currently exists in that county.

In no event shall the territorial boundaries of a hospital authority include, in whole or in part, the area of any previously existing hospital authority. All priorities shall

be determined on the basis of the time of issuance of the certificates of incorporation by the Secretary of State."

PART VII.--HEALTH DELIVERY IMPROVEMENTS

Sec. 7.1. G.S. 58-50-50 reads as rewritten:

"**§ 58-50-50. Preferred provider; definition.**

The term 'preferred provider' as used in Articles 1 through 64 of this Chapter with respect to contracts, organizations, policies or otherwise means a person, who has contracted for, or a provider of health care services who has agreed to accept special reimbursement or other terms for health care services from any person; or an insurer subject to the provisions of Articles 1 through 64 of this Chapter or other applicable law for health care services on a fee for service basis, or in exchange for providing health care services to beneficiaries of a plan administered pursuant to Articles 1 through 64 of this ~~Chapter.~~ Chapter, except that the term 'preferred provider' as used in Articles 1 through 64 of this Chapter does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Except where specifically prohibited either by G.S. 58-50-55 or by regulations promulgated by the Department of Insurance, not inconsistent with Articles 1 through 64 of this Chapter, the contractual terms and conditions for special reimbursements shall be those which the insurer, health care provider and the preferred provider find to be mutually agreeable."

Sec. 7.2. G.S. 58-67-10(b) reads as rewritten:

"(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health services or capitation arrangement.

(4) Except as provided in paragraphs (1), (2), ~~and (3)~~ (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article."

Sec. 7.3. G.S. 108A-55(b) reads as rewritten:

"(b) Payments shall be made only to intermediate care facilities, hospitals and nursing homes licensed and approved under the laws of the State of North Carolina or under the laws of another state, or to pharmacies, physicians, dentists, optometrists or other providers of health-related services authorized by the Department. Payments may also be made to such fiscal intermediaries and to ~~such~~ the capitation or prepaid health service contractors as may be authorized by the Department. Arrangements under which payments are made to capitation or prepaid health services contracts are not subject to the provisions of Chapter 58 of the General Statutes or of Article 3 of Chapter 143 of the General Statutes."

Sec. 7.4. Chapter 143 of the General Statutes is amended by adding the following new section to read:

"**§ 143-48.1. Medicaid program exemption.**

(a) This Article shall not apply to any capitation arrangement or prepaid health service arrangement implemented or administered by the North Carolina Department of Human Resources or its delegates pursuant to the Medicaid waiver provisions of 42 § U.S.C. 1396n, or to the Medicaid program authorizations under Chapter 108A of the General Statutes.

(b) As used in this section, the following definitions apply:

(1) 'Capitation arrangement' means an agreement whereby the Department of Human Resources pays a periodic per enrollee fee to a contract entity that provides medical services to Medicaid recipients during their enrollment period.

(2) 'Prepaid health services' means services provided to Medicaid recipients that are paid on the basis of a prepaid capitation fee, pursuant to an agreement between the Department of Human Resources and a contract entity."

Sec. 7.5. G.S. 90-85.29 reads as rewritten:

"**§ 90-85.29. Prescription label.**

The prescription label of every drug product dispensed shall contain the brand name of any drug product dispensed, or in the absence of a brand name, the established name. The prescription drug label of every drug product dispensed shall:

(1) Contain the discard date when dispensed in a container other than the manufacturer's original container. The discard date shall be the earlier of one year from the date dispensed or the manufacturer's expiration date, whichever is earlier, and

(2) Not obscure the expiration date and storage statement when the product is dispensed in the manufacturer's original container.

As used in this section, 'expiration date' means the expiration date printed on the original manufacturer's container, and 'discard date' means the date after which the drug product dispensed in a container other than the original manufacturer's container shall not be used. Nothing in this section shall impose liability on the dispensing pharmacist or the prescriber for damages related to or caused by a drug product that loses its effectiveness prior to the expiration or disposal date displayed by the pharmacist or prescriber."

Sec. 7.6. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 13A.

"Disposal of Surplus Property to Aid Other Countries.

"**§ 131E-248. Disposition of surplus property by public and State hospitals.**

(a) As used in this section, 'public hospital' has the same meaning as in G.S. 159-39. A State hospital is any hospital operated by the State.

(b) A public hospital or a State hospital may donate medical equipment it determines is no longer needed by the hospital to any:

(1) Corporation which is exempt from taxation under section 501(c) of the Internal Revenue Code of 1986;

(2) The United States or any agency thereof;

(3) Government of a foreign country or any political subdivision of that country;

(4) The United Nations or an agency of it; or to

(5) Other eleemosynary institutions and groups

if the property so donated is to be used by a hospital or medical facility in another country."

Sec. 7.7. Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.1. Counseling patients regarding prescriptions.**

(a) Any hospital or other health care facility licensed pursuant to this Chapter or Chapter 122C of the General Statutes, health maintenance organization, local health department, community health center, medical office, or facility operated by a health care provider licensed under Chapter 90 of the General Statutes, providing patient counseling by a physician, a registered nurse, or any other appropriately trained health care professional shall be deemed in compliance with the rules adopted by the North Carolina Board of Pharmacy regarding patient counseling.

(b) As used in this section, 'patient counseling' means the effective communication of information to the patient or representative in order to improve therapeutic outcomes by maximizing proper use of prescription medications and devices."

Sec. 7.8. Section 136(e) of Chapter 900 of the 1991 Session Laws reads as rewritten:

"(e) To the maximum extent possible, Area Mental Health Authorities are encouraged to develop service implementation plans in accordance with the long-range plans of the Mental Health Study Commission and with the involvement of local affected organizations. These plans may be used as the basis for future budget requests submitted by the Division.

Criteria for development and content of these plans shall be developed by the Department of Human Resources and the members of Coalition 2001 and presented to the Mental Health Study Commission for consideration by November 1, 1992. The plans themselves shall be ready for review by the Department and the Mental Health Study Commission by ~~November 1, 1993.~~ November 1, 1993, February 1, 1994, and May 1, 1994."

Sec. 7.9. Sections 7.1, 7.2, 7.3, and 7.4 of this act apply to arrangements implemented or administered on or after July 1, 1993. Section 7.7 becomes effective July 1, 1994. Section 7.5 becomes effective January 1, 1994.

PART VIII.--SEVERABILITY AND EFFECTIVE DATE

Sec. 8.1. The provisions of this act are severable. If any provision of this act is held invalid by a court of competent jurisdiction, the invalidity does not affect other provisions of the act that can be given effect without the invalid provision.

Sec. 8.2. The Part headings in this act are for reference only and do not enlarge, define, or restrict the scope of this act unless otherwise expressly indicated.

Sec. 8.3. Except as otherwise specified herein, the provisions of this act are effective upon ratification.

In the General Assembly read three times and ratified this the 24th day of July, 1993.

DENNIS A. WICKER

Dennis A. Wicker
President of the Senate

DANIEL BLUE, JR.

Daniel Blue, Jr.
Speaker of the House of Representatives

Appendix B

Minutes

MINUTES
NORTH CAROLINA HEALTH PLANNING COMMISSION
OCTOBER 26, 1993

The first meeting of the North Carolina Health Planning Commission was held on Tuesday, October 26, 1993 at 10:00 a.m. in Room 1228 of the Legislative Building, Raleigh. Fifteen members were present. (Visitor Registration Sheet and Agenda are Attachments 1 and 2)

Governor Hunt called the meeting to order and welcomed members and visitors. In opening remarks, the Governor said, "the Commission was created because of the importance of health care reform within our state. We have a trememdous task and an awesome responsibility. It is one we cannot shirk from."

Commission members introduced themselves and made brief comments at the request of the Governor.

The Governor called the attention of members to a form in the notebooks which was supplied for recommendations by members of any individuals or groups wanting to testify before the Commission. (Attachment 3)

Mr. Linwood Jones, General Assembly Staff Attorney, was recognized to review the health care reform measures contained in House Bill 729, the Jeralds-Ezzell-Fletcher Health Care Reform Act of 1993. (Legislative Overview, Attachment 4 and a copy of HB 729 is Attachment 5)

Mr. Jones noted that Subsection (d), Page 9 of HB 729 makes it clear, that notwithstanding any other provisions in the legislation, the NC Health Planning Commission may develop a health care proposal, or plans, or make any recommendations to the General Assembly. According to Mr. Jones, this language was placed in the bill to provide flexibility and discretion for the Commission in developing a health plan.

Regarding a timetable for the Commission reporting, Mr. Jones stated there is no statutorily-imposed deadline for the implementation of the health care plan. The Commission must report to the General Assembly by April 1, 1994 with an "outline" on its health care reform proposal. How detailed the outline is depends on whether the Commission elects to await final congressional action on a national health care plan.

By April 1, 1995, the Commission is to provide a progress report on the development of its health care proposal. The Commission is to continue reporting each April on findings, recommendations and activities until the final plan is approved.

Mr. Jones pointed out that the General Assembly may, at anytime, change the powers, duties, functions and composition of the Commission. Reporting deadlines and requirements may also have to be adjusted to respond to federal health care reform legislation. Once the General Assembly implements a plan, it is expected a full-time professional seven member Commission, appointed by the Governor, would be appointed to oversee implementation.

On a motion by Representative Mavretic, action was taken regarding Section 143-611(d), Page 7, HB 729. The Governor will continue to call the meetings of the NC Health Planning Commission and chair those meetings with the Speaker of the House and President Pro Tempore of the Senate to act as Co-Vice Chairmen and for them to preside, if required, in that order alternatively. Seconded by Secretary Howes.

Senator Basnight, Speaker Blue and the Lieutenant Governor each made a statement to the Commission.

Concerning the search for an Executive Director, the Governor stated the application process was still open.

On a motion by Senator Sands, a subcommittee consisting of the Governor, the President Pro Tempore and the Speaker was appointed to review the applications and hire an Executive Director for the Commission. Representative Mavretic seconded.

Ms. Barbara Matula, Division of Medical Assistance, Department of Human Resources gave a brief review of federal health care reform efforts. Ms. Matula provided a brochure covering the highlights of the President's proposal. (Attachment 6)

The basic principle of the plan is guaranteed coverage for all Americans, a comprehensive benefits package with security, simplicity, savings, choices, quality and responsibility.

In response to a question by Senator Sands, Ms. Matula said the states can choose to participate in the federal plan, but there would be a financial penalty for not choosing to participate.

Senator Sands asked for the costs of the various proposals prior to the next Commission meeting. Ms. Matula said the information may not be known that early, but, if available, it would be provided.

At the request of Senator Perdue, a summary prepared by Ms. Matula will be mailed to members.

The next meeting will be held on November 30, 1993 from 10:00 a.m. until 1:00 p.m.

The meeting was adjourned at 11:05 a.m.

Judy Britt
Commission Clerk

Governor James B. Hunt, Jr.
Chairman

MINUTES
NORTH CAROLINA HEALTH PLANNING COMMISSION
NOVEMBER 30, 1993

The second meeting of the North Carolina Health Planning Commission was held on Tuesday, November 30, 1993 at 10:00 a.m. in Room 643 of the Legislative Office Building. Eleven members were present. (Visitor Registration Sheet and Agenda are Attachments 1 and 2)

Governor Hunt called the meeting to order. In opening comments the Governor said the purpose of the meeting was to review some of the work that has been done by various groups toward health care reform in North Carolina.

On a motion by Senator Sands, seconded by Senator Kaplan, the minutes of the October 26, 1993 meeting were approved. (Attachment 3)

Dr. William C. Friday was recognized by the Governor as Chairman of the Institute of Medicine Health Access Forum. Members of the Forum who were present were introduced.

Dr. Friday stated the Forum was appointed in early 1991 with membership composed of leaders representing business, state government, labor, consumers and the health care industry. The Forum held 20 meetings and worked toward developing a proposal that would ensure that all North Carolina citizens have access to a high level of quality health care at an affordable cost to their families.

Following opening comments, Dr. Friday introduced Dr. Duncan Yaggy, Chief Planning Officer, Duke University Medical Center, Durham to review the fundamental principles defined by the Forum as necessary for a basic health program for all. (An Executive Summary of the Health Access Forum proposal is Attachment 4)

Dr. Yaggy defined the policy goals and general principles established by the Forum as outlined in the Executive Summary.

Mr. Lanty L. Smith, Chairman and CEO, Precision Fabrics Group, Inc., Greensboro to give a general review of some of the problems associated with health care access and how business is affected.

Mr. Smith stated there are more health care costs in an automobile being made in Detroit than there are costs of steel in the vehicle. The United States spends more money per capita and more money as a percent of the gross domestic product (13%) than any other nation in the world by a large margin. Japan spends less than 6%, Germany 8% and Canada 9%.

Mr. Smith said "it makes no sense to have health care tied to employment." He then gave a brief history of how the United States developed the policy of employment based health benefits.

In response to a question by Senator Kaplan, Mr. Smith said most other countries do not use an adversarial legal system to resolve complex issues like medical malpractice. The first objective should be to try to prevent malpractice from occurring, the second should be to try to provide appropriate, but certain, compensation for the victim. That is the direction other developed countries take rather than having a state-by-state approach as practiced in the United States.

Ms. Pam Silberman, Project Director, NC Health Access Coalition, made a slide presentation outlining several problems in the current health care system as identified by the Coalition. A copy of Ms. Silberman's remarks with background information is included in the record as Attachment 5.

The Governor announced that Senator George Daniel, who was scheduled to review the work of the Commission on Access to Health Insurance as the Chairman of that group, was unable to attend due to a business conflict. Senator Daniel's presentation would be rescheduled. Also, the Governor said the Commission would hear from Lt. Governor Wicker on small business initiatives.

Representative Joe Mavretic spoke to the Commission as Chairman of the House Select Committee on Health Care Reform for North Carolina. The proceedings of the select committee were made available to members. That committee held 18 hours of public hearings with testimony of all but one special interest group associated with health care reform issues.

As a part of the presentation, Representative Mavretic gave some historic background information on the health care issue in the United States and how it has changed through the generations.

Continuing, Representative Mavretic emphasized that the recommendations of the House Committee were based on health and health status, not health access. "Access to health care is not the most pressing issue; it simply addresses a subset of the most pressing issue which is the improvement of health status for 6.8 million North Carolinians in the 37th poorest state in the Nation. Wellness versus illness is the issue, and prevention instead of treatment is the only significant way to properly allocate our scarce resources."

The issue of specialist physician and primary care physician was addressed by Representative Mavretic as well as medical malpractice.

Senator Kaplan asked if pediatricians, OB/GYN physicians and others were included in the definition of primary care physician. Representative Mavretic responded there has been no agreement on the definition. These are the kinds of issues that need to be resolved.

The Governor brought to the attention of the Commission a book recommended by Representative Dickson entitled, Logic of Health Care Reform. Staff will provide copies to all members.

Regarding the selection process for an Executive Director, the Governor announced the list of nominees had been narrowed from 170 candidates to seven by the selection committee. The seven would be personally interviewed on December 15.

On Friday, December 17, the Commission will hold the next meeting and a recommendation for the Executive Director will be made at that time. Also, the agenda for that meeting will involve a briefing on health status in North Carolina with statistical data and commentary.

The meeting was adjourned at 12:20 p.m.

Judy Britt
Commission Clerk

Governor James B. Hunt, Jr.
Commission Chairman

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

December 17, 1993

Governor James B. Hunt, Jr., Chairman of the NC Health Planning Commission, called the third meeting to order at 1:13 p.m. on December 17, 1993 in Room 643 of the Legislative Office Building. Governor Hunt welcomed the fifteen members of the commission who were present as well as visitors. Representative Dub Dickson moved that the minutes of the previous meeting be approved as there were no corrections. The motion was seconded by Department of Human Resources Secretary Robin Britt and the motion passed. The agenda and a visitors list is attached.

Governor Hunt brought the members' attention to the fact that a statement of principle of the Institute of Medicine which had been requested by Mr. Bill Friday was in the front of the commission notebooks. The Governor also reminded the commission that it had been decided earlier to use this particular meeting to be an update on the health status of the people of North Carolina and the problems and needs of the citizens.

Mr. Christopher Conover, an Associate in Research at the Center for Health Policy Research and Education at Duke University, was introduced by the Governor who explained that the focus of this presentation would be on the cost of and access to health care in this state.

Mr. Conover presented a series of slides which helped him explain the ten "myths" of health care reform. (See Attachment #1 for replicas of these slides). He explained that the risk of being uninsured was linked to income and discussed the percentages of workers who cannot afford health coverage. He further discussed universal coverage and the mechanics of cost shifting. He explained that often the privately insured citizens help pay for the costs of those uninsured citizens and the driving force there is that Medicare and Medicaid are paying less than it has in previous times. Mr. Conover pointed out that the net cost of Universal Coverage in North Carolina in 1993 would be $392.7 million.

Another point Mr. Conover made was that offering limited health benefits as a plan for uninsured or offering employer

subsidized plans had proven unpopular because many workers are not willing to pay for the coverage. Also, that in those firms where the employer is paying for health care, usually the wages paid the employees are lower.

Mr. Conover concluded his presentation by discussing the fact that North Carolina cannot afford to wait for the Federal Government to take action but must take the lead in health care reform. He also discussed North Carolina in comparison to other states with regard to health care reform and stated that this state is not much different from other states.

Governor Hunt thanked Mr. Conover for his presentation and opened the meeting for questions by the commission members.

Representative Joe Mavretic was recognized to ask his questions and asked Mr. Conover about the slide which stated that "In North Carolina, nearly 800 uninsured die each year that universal coverage is delayed" (see the second sheet, top right of Attachment #1). Representative Mavretic questioned the statistics regarding this issue and Mr. Conover cited the statistics on infant mortality in North Carolina and said that 125 infants have been saved per year. Representative Mavretic also questioned the "see-saw" where the major sources of cost savings were only cited on one side, but failed to make connections for those extraordinary cost savings the state could have on the other side in eliminating waste, saving money and improving quality.

Mr. Conover responded to Representative Mavretic by stating that universal coverage is giving everyone access to the system. He further stated that if universal coverage is coupled with health care reform, the savings from reform can pay for universal coverage. Representative Mavretic stated that the House Select Committee on Health Care Reform came to the above stated conclusion in about the third month of its deliberations.

Representative Mavretic questioned Mr. Conover's part of the presentation which stated that large firms pay 5 times for health care. He also stated that"the great lobby fight in Washington to date has been the major companies, who say not no, but hell no, we are not going to be required to come under a universal national plan." Mr. Conover answered by stating that the larger employers are concerned about losing

control over their health benefits. Mr. Conover also stated that he did not say that the companies pay 5 times as much, but that the companies pay 5 different times or about 25% more than the cost of the care for the individuals because of the other add-ons, because they are paying for care for someone else. Representative Mavretic questioned why it would not be to the advantage of these companies to reduce an extraordinary cost to each company. Mr. Conover answered by stating that normally, the larger companies were not of the same mind about health care benefits.

Representative Mavretic further stated that Mr. Conover had not made his case in "the return on investments in prevention." Representative Mavretic pointed out that the "bottom line" on almost every chart was that prevention pays and lifestyle changes pay but the myth itself stated "Health Promotion/Disease Prevention Can Do It All". He further stated that while he felt no one believed health promotion and disease prevention could indeed do it all, but would be an extraordinary pay-off that would have to be addressed.

Governor Hunt recognized Representative Karen Gottovi who made several points about the two-tier programs system which was set up in Tennessee and how this could affect the rural poor.

Representative Richard Moore was recognized by Governor Hunt at this time. Representative Moore asked Mr. Conover's opinion on how North Carolina ranked in how the state recovers information. Representative Moore further stated that he was impressed during the presentation with the overuse of medical procedures and this was a major problem. He further stated that identifying medical procedure overuse is more complicated and from information from New York, Vermont and Maine, they seem to be struggling with gathering data the right way and asked if North Carolina was doing this correctly. Mr. Conover stated that every state feels that they can improve their data gathering process and declined to rank North Carolina. He did state that the fact that North Carolina did create the Medical Data Base Commission was a step in the right direction.

Governor Hunt recognized Senator Beverly Perdue, who stated that after looking at Mr. Conover's recommendation that North Carolina should not wait for the federal government to become involved, but to divide the state into

purchasing pools she would have to raise a question she had done many times before. She wanted to know how those citizens who live in rural, under-served areas with no medical facilities could be served by a pool or should they fund subsidized health clinics. Mr. Conover explained that the virtue of competition is that the market often will fill in shortages, but in rural areas they sometimes do not have the purchasing power to attract physicians. He also explained that it would not be enough to create the pools but that money would have to be put behind every rural resident to give them the ability to purchase decent coverage. He stated that under a competitive market plans would probably start to go into those remote rural areas. He also cited plans where areas could have a Nurse Practitioner running a clinic with the appropriate back-up instead of a physician.

Senator Perdue asked a follow-up question about what to do with citizens who live on border counties, where the nearest medical facility is across the border in another state. She also wanted to know how people could be prevented from going into other states for care if the citizens were forced into a pool group or managed care financed by North Carolina. Mr. Conover stated that this type of system should network between states and have contractual agreement with facilities.

Senator Sandy Sands was recognized by Governor Hunt and requested some information on the issues of Health Promotion/Disease Prevention. Senator Sands wanted to know where the data comes from and stated that he had been trying for over a year to get the underlying figures other than on a chart. Governor Hunt directed Mr. Conover to obtain the statistics on smoking, alcohol and diet.

Governor Hunt recognized Representative Dub Dickson, who asked Mr. Conover to elaborate on how competition works in a flawed health system. (See the 6th sheet on the handout, top right) Representative Dickson stated he was confused by the "Note" at the bottom of this slide, which stated, "U.S. health system is most intensively regulated sector of the U.S. economy." Mr. Conover stated that every doctor cannot practice medicine unless they are licensed and all hospitals go through certificate of need - so everywhere health care is regulated and is not a free market. Representative Dickson also asked questions with regard to the $500 million Mr. Conover has stated would be necessary to insure the uninsured

or under-insured in North Carolina. Discussion ensued and Mr. Conover stated he had based this cost on a comparison of bringing uninsured to the same level as those privately insured.

Governor Hunt thanked Mr. Conover for his presentation. Senator Sandy Sands moved to convene an Executive Session of this commission for the sole purpose of discussing a personnel matter. Representative Joe Mavretic seconded the motion and the motion passed.

The meeting was recessed at 2:30 p.m. so that the Executive Session could begin.

* * * *

Governor reconvened the commission meeting at 3:20 p.m. He explained to the visitors as the commission members were taking their seat to resume, that the Speaker, the President Pro Tempore and he had spent a good portion of the day on Wednesday interviewing candidates for the position of Executive Director of this commission. He stated that this process was very informative as the commission panel had learned from the candidates about what is happening all over the country and what various states are doing. He further stated that our rural health clinics were cited as the best in America and that other states were trying to emulate them. Also that our public health system and our private health system received plaudits which the Governor stated would have made the commission and the citizens pleased and proud.

Governor Hunt announced that a decision about the recommendation for Executive Director for the commission had been discussed in executive session. The Governor recognized Speaker Dan Blue for a motion with regard to the Executive Director.

With regard to the position of the Executive Director for the North Carolina Health Planning Commission, Speaker Dan Blue made the following motion: "Following extensive interviews and review of records and accomplishments of some very fine candidates, the Governor, the President Pro Tempore and I offer to you, or recommend to you that the commission

employ Dr. Jim Jones of Pitt County, North Carolina as the Executive Director of the Health Planning Commission. Dr. Jones has extensive experience in managing large, complex organizations. He has headed the Family Medicine Department at East Carolina; in fact, he was the founding chairman of that department. He has been very active in a wide range of professional activities and has, I think, a significant grasp of the issues facing us as a commission. He does not bring any particular bias to this particular post and Governor, given all the other circumstances, we recommend Dr. Jones to you with our highest recommendation because of our belief in his ability to help this commission attack the health care problems in North Carolina." Representative Thomas Wright seconded the motion made by the Speaker. Governor Hunt asked if there were other candidates to come from the commission and being none, Senator Sands moved that the nominations be closed and that Dr. Jim Jones be elected by acclamation. Representative Dub Dickson seconded this motion and the motion carried unanimously.

Governor Hunt congratulated Dr. Jones and requested that he stand and be recognized by the commission and visitors. Dr. Jones received a round of applause. The Governor reminded the commission and visitors that Dr. Jones had grown up in Robeson County, went to school at Mars Hill, went to Wake Forest and he served at the Naval Academy where he did his residency. The Governor stated that Dr. Jones reflects all of the state with his experiences.

Governor Hunt recognized Dr. Ron Levine, the State Health Director for his portion of the presentation to the commission. Dr. Levine congratulated Dr. Jones, a colleague of long standing, on being elected to the position of Executive Director of the commission

Dr. Levine stated that "as this state and nation debate health system reform, there is a clear consensus that the plan that ultimately emerges must be based on the principles of, (1) universal access to high quality, cost worthy health services and (2) reduction in the growth in health care costs." He further told the commission that "somewhat muted, unfortunately, in the debate is the recognition that the ultimate goal of America's health care system is improved health status and that this measure must be constantly before us as we design, implement and fine tune this new system." (See Attachment #2 for Dr. Levine's slide explanation.)

Dr. Levine discussed the general health of our North Carolina citizens in contrast with the rest of the world and contrasted the sub-populations within the state. Dr. Levine stated that North Carolina has a higher mortality rate among men over women, among minority over whites, with the highest being minority males versus all others. He also discussed prenatal care, general health relating to smoking and alcohol and the capacity of the local health departments to meet the needs of North Carolina citizens. The three conclusions that Dr. Levine came to were: (1) North Carolina is not the healthiest of states. He stated that while North Carolina was healthier than ever before compared to the national picture, citizens are not as healthy as they should be. (2) Certain areas of this state and sub-populations of our citizens are in particularly poor health and require special attention and (3) strategies beyond traditional curative medical care is needed is we are truly to improve over-all health status. De. Levine strongly advocates preventative health services.

Governor Hunt asked if there were questions from the commission with regard to Dr. Levine's presentation.

Representative Karen Gottovi requested that handouts be made more readable, citing that charts were hard to decipher because of lack of coloration as was done on the slides. Governor Hunt reiterated Representative Gottovi's request and asked that from this point on, readable handouts be done in advance.

Representative Joe Mavretic was recognized by the Governor. He asked the commission members when they look through the handout provided by Dr. Levine (Attachment #2) on Health Status, to note that "the reason the House Committee on Health and Human Services came to the conclusion that North Carolina ought to be divided into community health districts comprised of one or more counties, is that if you look at those hundred counties with the different colors, that represent a statistic on a particular indicator, and could pull an acetate overlay over these as you identify the indicators; what it clearly tells you is that different parts of North Carolina have different health status problems - and if you try to make one plan fit all, you can't do it in North Carolina because the problems of northeastern North Carolina are almost like another country different from the problems

of the central piedmont. And that from our point of view was the compelling reason to look at community health districts within this state."

Governor Hunt asked if there were other questions or comments by members of the commission and thanked Dr. Levine for his presentation.

The Governor asked if there was any further business for the commission and announced that the next meeting was scheduled for January 19th from 10:00 a.m. until 1:00 p.m. in Room 643 of the Legislative Office Building. At this time, Senator George Daniel is scheduled to make the presentation that he could not make at the meeting on November 30th. Also, Lieutenant Governor Dennis Wicker will be asked to present the work of his commission. Governor Hunt also stated that the commission would spend a considerable amount of time on President Clinton's proposal and other proposals at the national level so the commission could begin to have that information. The Governor requested that Dr. Jones be available to the press and anyone who wished to speak to him after the meeting.

Governor Hunt reminded the staff that Representative Mavretic had asked that the commission have an update on the progress toward organizing a State Department of Health, which was included in legislation and asked that this be ready at the next meeting.

The Governor wished the commission and visitors happy holidays and adjourned the meeting at 3:45 p.m.

Nancy Wooten Green
Committee Clerk

Governor James B. Hunt, Jr.
Commission Chairman

MINUTES
NORTH CAROLINA HEALTH PLANNING COMMISSION
JANUARY 19, 1994

The North Carolina Health Planning Commission met at 10:00 a.m. in Room 643 of the Legislative Office Building. Governor Hunt called the meeting to order. There were fourteen members present in addition to the Governor. The agenda is attached.

Minutes of the December 17, 1994 meeting were before the Commission for approval. There were two corrections. On page 2, paragraph 6, line 5 add the word "say" at the beginning of the sentence and on page 6, paragraph 2, line 6 change the word "in" to read "at" the Naval Academy. On a motion by Senator Sands, the minutes, as amended, were approved. (Attachment 1)

Dr. James Jones, the newly appointed Executive Director of the Commission, was recognized for comments. As of February 1, Dr. Jones may be reached in the office of Secretary Britt at 733-4534.

Outlining the Commission working structure, Dr. Jones stated that a weekend retreat was being planned to hear from individuals involved with other state health care reform initiatives. Calendars for possible dates were provided members. Also, task force or advisory groups will be formed. Members of the Commission will be asked to serve as co-chairs along with individuals outside of government, and may participate with each group as ex officio members. An oversight committee will also be established. Dr. Jones asked to be advised by members of their particular committee assignment interest.

Dr. Jones announced that Ms. Pam Silberman has been appointed as Deputy Executive Director to join the staff the middle of February.

Lt. Governor Wicker, Chairman, State Health Plan Purchasing Alliance Board, presented an overview of the work of that Board. (Attachment 2) The Lt. Governor introduced the Board members who were present.

Senator George Daniel, who had served as chairman of the Access to Health Insurance Commission, was recognized to review the legislation coming from the recommendations of that Commission. (Attachment 3)

In response to a question by Representative Gottovi regarding SB 4 and 5, expansion of the Medicaid program, Senator Daniel said that $200,000 was appropriated to develop a plan for implementation in the event these two bills are enacted.

The Governor introduced Dr. Ken Thorpe, Deputy Assistant Secretary of Planning and Evaluation-Health Policy in the Department of Health and Human Services. Dr. Thorpe was before the Commission to bring an update on the Health Care Reform legislation of the President.

Specific areas to be addressed included: a general overview of the President's plan, a review of the legislative schedule of that plan, areas where states can receive waivers, a comparison of the plan to the major alternatives offered, and what North Carolina should be doing now while the federal government is working toward final legislation. (Copies of the slides and a transcript of Dr. Thorpe's comments are Attachment 4)

Following the slide presentation, the floor was opened for questions and answers. A review of those questions and responses is a part of Attachment 4.

Governor Hunt announced the upcoming Emerging Issues Forum and that the First Lady would speak on Thursday, February 10.

The next meeting will be held on February 16, 1994 at 10:00 a.m. in Room 643 to discuss how other states are approaching health care reform measures. Members will be notified if there is any change in time or date.

Judy Britt
Commission Clerk

Governor James B. Hunt, Jr.
Commission Chairman

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

April 20, 1994

The North Carolina Health Planning Commission met at 10:00 a.m. in Room 643 of the Legislative Office Building. Governor James B. Hunt, Jr., Chairman of the NC Health Planning Commission, called the meeting to order at 10:10 a.m. Twelve Commission members were present in addition to Governor Hunt. Representative Dub Dickson moved that the minutes of the previous meeting be approved as there were no corrections. The motion was seconded by Senator Forrester and the motion passed. A copy of the agenda is attached.

Governor Hunt welcomed the Commission members and presented the Principles that outline the work of the commission. (See Attachment #1) The Governor also discussed the possibility of an all day meeting for the Commission on May 18th for an overview of what other states have done with regard to Health Reform.

Dr. James Jones was introduced and he in turn introduced the NC Health Planning Commission staff. (See Attachment #2) . Dr. Jones presented the Workplan of the Commission , the survey of members to be used "in-house" by the staff only, and a draft of the Report to the General Assembly by the Commission. (See Attachments #2- #5) Representative Joe Mavretic explained that the report to the Commission was essentially the same as that found by the House Select Committee on Health Care Reform and moved for the Commission to adopt the report with a notation that the report was submitted 19 days late. Motion passed and the report was approved.

Governor Hunt urged the members of the Commission to complete the anonymous survey and return it to the staff by May 1st.

Mr. Randy Madry, Deputy Commissioner for the Department of Insurance (919 715-0526) was recognized to give his report to the Commission on Financing Models. (See Attachment #6) Discussion ensued.

The Governor recognized Ms. Anna M. Lore, Health Plan Manager for Kaiser Permanente (919 878-5806) to give a report on Group Model HMOs. (See Attachment #7) .Discussion ensued.

Mr. Bob Greczyn, Corporate Executive Officer for Carolina Physicians Health Plan (919 460-1624) was recognized to give his report on Managed Care Arrangements. (See Attachment #8 - #8b). Discussion ensued.

Dr. Duncan Yaggy, Chief Planning Officer of the Duke Health Network, presented his report with regard to Physician Hospital Organizations. Discussion ensued.

Dr. Harry Nurkin, President of the Charlotte/Mecklenburg Hospital Authority also discussed Physician Hospital Organizations Discussion ensued.

Governor Hunt asked for opinions from the Commission members about extending the meeting time on May 18th. It was the general consensus that this would be a good idea and May would be a good time to start. The Governor also re-emphasized the suggested workplan of the Commission and again urged the members to complete the surveys.

Governor Hunt adjourned the meeting at 1:05 p.m.

Nancy Carolyn Wooten, Commission Staff

Governor James B. Hunt Jr., Chairman

NOTE: For copies of the attachments mentioned in the minutes, please contact the presenters directly at the telephone number provided.

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

May 18, 1994

The North Carolina Health Planning Commission met at 9:30 a.m. in Room 643 of the Legislative Office Building. Governor James B. Hunt Jr., Chairman of the Commission called the meeting to order at 9:35 a.m. A copy of the meeting agenda is attached. Governor Hunt inquired if there were any changes to the minutes of the previous meeting, at which time Representative Dub Dickson moved that the minutes be approved. The motion was seconded and the motion passed.

Governor Hunt welcomed the Commission members, discussed the agenda and announced the completion of the membership selection for the Advisory Committees of the Commission. (See attachment #1 for a listing of the committee co-chairmen and the staff assigned to each committee.)

Governor Hunt introduced Representative Ernesto Scorsone of the Kentucky State House of Representatives (606 254-5766) who was one of the leading advocates for health care reform and a primary architect of the Health Care Reform Act of 1994 in Kentucky. He explained that Kentucky produced their health care reform plan because they did not feel that the federal government could do it all. Representative Scorsone discussed the efficiency of their plan. He also reminded members of the Commission that since the actual bill in Kentucky had just passed on April 15th of this year, there was no track record at this time. Representative Scorsone provided the Commission members with a copy of a summary of Kentucky's plan as well as a citizens handbook. (See Attachment #2 and #2a)

Ms. Trish Riley, Executive Director of the National Academy for State Health Policy (207 874-6524), was introduced by Governor Hunt. Ms. Riley gave an overview of state health reform initiatives and state health care reform strategies by California, Florida, Hawaii, Kentucky, Minnesota, New York, Oregon, Tennessee, Vermont and Washington. (See Attachments #3, #3a and #3b) Discussion ensued and questions were entertained by Ms. Riley from the Commission. Ms. Riley did stress that the states need to build and promote primary care and also primary care physicians.

At this time, Speaker Dan Blue introduced Representative Steve McDaniel of the Tennessee State House of Representatives (615 741-0750). Representative McDaniel served for three years on the Senate Joint Health Care Study Committee where he chaired the subcommittees on Medicaid Reform and the Tennessee Health Facilities Commission.

He was Secretary of the 14 member TennCare Legislative Oversight Committee that implemented reform in Tennessee's Medicaid Program. Representative McDaniel gave a brief overview of the TennCare Program and some of the initial problems with implementation . He then entertained questions from the Commission members. Because of the voluminous size of the TennCare Plan, he did not hand out information to the members, but did provide Dr. Jones with a copy of the plan for use by the Commission Staff in their efforts to serve the Commission.

Governor Hunt recessed the Commission meeting for a brief break and reconvened at 12:45 p.m., at which time lunch was served to the members of the Commission and work progressed for the afternoon portion of the meeting. During lunch, Pam Silberman, Deputy Director of the Health Planning Commission gave a federal update including a summary of various national health reform plans. (See Attachment #4, #4a and #4b).

Governor Hunt led the discussion of the Principles of the Commission. The Commission agreed to review the principles and make tentative recommendations to be deferred for final action until the July meeting. The following reflects the actions taken by the Commission:

1. **Universal Coverage** - Representative Mavretic suggested to eliminate the word "insurance" and change "or access" to "and access" and moved to make these amendments. Representative Thomas Wright seconded the motion and after much discussion, the motion passed. Principle #1 was adopted as amended. Later during discussion of principle #7, Speaker Blue suggested that "reasonable" be added to "and access" , making it "and reasonable access". Speaker Blue moved to do so. Motion passed.

2. **Cost Containment** - Lieutenant Governor Dennis Wicker questioned whether or not the issue of managed care should be a part of the principles. After discussion, Representative Dub Dickson moved to adopt #2 as written. Representative Karen Gottovi seconded the motion and the motion passed. The principle was adopted.

3. **Comprehensive Benefits Package** - Representative Dickson moved for adoption as written of this principle. Lieutenant Governor Wicker seconded the motion. After discussion, the motion passed and the principle was adopted.

4. **Choice** - Lieutenant Governor Wicker moved for adoption of this principle. Representative Mavretic moved that "within the confines of overall affordability" be omitted from the language. Representative Gottovi questioned the word "providers" as

not being specific enough. Speaker Dan Blue requested more specific language to specify what kind of provider could be utilized. Representative Dickson made a substitute motion to omit the words "of providers and" as well as "within the confines of overall affordability. Representative Gottovi moved to defer action on this principle until staff had a chance to work on the language. This motion passed and the principle was deferred.

5. **High Quality Services** - Representative Mavretic moved to change the title of this principle to "Coordinated Services". Representative Gottovi seconded this motion and after discussion, the motion passed. This principle was adopted as amended.

6. **Emphasis on Improving Health Status** - Representative Dickson moved for adoption of this principle as written. Representative Wright seconded this motion and the motion passed. The principle as adopted.

7. **Access to Services** - Representative Mavretic moved to omit this entire principle and Senator Ted Kaplan seconded the motion. After discussion the motion passed to omit this principle.

8. **Affordability** - Representative Mavretic moved to defer this principle and have staff reconsider the language. After discussion, motion passed and this principle was deferred.

9. **Personal Responsibility** - Representative Wright moved to adopt this principle as written. Representative Dickson seconded and after discussion, the motion passed. This principle was adopted.

10. **Simplicity** - Representative Wright again moved to adopt this principle as written. Representative Dickson seconded the motion and the motion passed after discussion. This principle was adopted.

11. **Community Involvement** - Representative Mavretic suggested that the title of this principle be changed to "Community Autonomy". Representative Gottovi moved to keep the principle the same but defer until the language could be reworked. Representative Wright moved to keep the principle the same and after much discussion, Representative Mavretic seconded this motion and the motion passed. The principle was adopted.

12. **Licensed or Certified Health Professionals** - Representative Dickson questioned the word "appropriate". Discussion ensued and Representative Dickson

moved for adoption of this principle. Representative Gottovi seconded the motion and the motion passed. The principle was adopted.

At the conclusion of the discussion of the principles, Governor Hunt inquired of the commission members if there were any additions to the principles and none were offered.

Governor Hunt introduced Dr. James G. Jones, Executive Director of the NC Health Planning Commission, who explained the workplan of the commission. (See attachment #6) Dr. Jones also explained the need for full day commission meetings from this time forward because of the extensive amount of work the commission has to accomplish and the deadlines which have to be met. Dr. Jones further advised the members of the commission that the advisory committees were to begin work in June. Questions were entertained by Dr. Jones.

Governor Hunt discussed the time for the next commission meeting with the members and it was decided to meet in July. Governor Hunt adjourned the meeting at 2:45 p.m.

Nancy Carolyn Wooten
Commission Staff

Governor James B. Hunt Jr., Chairman

NOTE: For copies of the attachments mentioned in the minutes, please contact the individual presenters directly at the telephone number provided.

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

July 20, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on July 20, 1994. Governor James B. Hunt Jr., Chairman of the Commission called the meeting to order at 9:10 a.m. A copy of the agenda is attached. Commission members present included: Lieutenant Governor Dennis Wicker, Secretary Robin Britt, Secretary Jonathan Howes, Speaker Dan Blue, Representative Joe Mavretic, Representative Dub Dickson, Representative Thomas Wright, Representative Karen Gottovi, Senator Beverly Perdue, and Senator James Forrester. Governor Hunt inquired if there were any changes to the minutes of the previous meeting, at which time Lieutenant Governor Wicker moved that the minutes be approved. The motion was seconded by Representative Mavretic and the motion passed.

Governor Hunt welcomed the Commission Members and discussed the agenda. At this time, reconsideration and adoption of the Commission Principles was on the agenda; however, because all Commission members were not present to discuss these in detail, the Governor expressed concern about considering the principles on this date. Representative Joe Mavretic moved to remove this item from the agenda and calendar it for the next meeting to be held on August 23, 1994. Representative Gottovi seconded the motion and the motion passed. Governor Hunt suggested that any presentation of new principles be allowed at this meeting and then considered and discussed at the next meeting. Representative Gottovi presented a suggested Principle on Medical Liability Reform and copies were handed out to the members. (See Attachment #1)

Governor Hunt recognized Dr. James G. Jones, Executive Director of the Commission to give his report on the progress of the Commission work. Dr. Jones also explained the reasoning behind the setting of copying fees by the commission staff. (See Attachment A)

Representative Joe Mavretic requested that an economic analyst be hired to give the Commission an overview of the true nature of the economics of health reform. The Governor agreed that this was a good idea and requested the staff to have someone do an economic analysis.

The Governor recognized Ms. Kathy Elmore who testified as to the problems for the uninsured and underinsured on behalf of her daughter, Megan. (see Attachment #2) After her presentation, Ms. Elmore entertained questions from the Commission.

Ms. Vanetta Washington was recognized by Governor Hunt to testify on the problems of the uninsured and underinsured on behalf of her daughter, Brittany. (see Attachment #2b) After her presentation, Ms. Washington entertained questions from members of the Commission.

Mr. Chris Conover from the Duke Center for Health Policy Research and Education gave a presentation on the description of the medically uninsured in North Carolina. (See Attachment #3, #3a and #3b) Discussion ensued with regard to Medicaid and Medicare access for the uninsured. Representative Thomas Wright requested a breakdown on this information for children per county. Mr. Conover allowed that he could provide this information per county, by age and would do so.

Governor Hunt recognized Ms. Diane Coats from Salisbury, who addressed problems for Medicaid and Medicare recipients from personal experience. (See Attachment #4)

Barbara Matula, Director of the Division of Medical Assistance was recognized to give an overview of the problems of Medicare and Medicaid programs. (See Attachment (5) Discussion ensued regarding income and assets that people could have before Medicaid could be used to cover needy citizens.

Mr. and Mrs. Thomas of Goldsboro gave their testimony with regard to problems for Medicaid and Medicare recipients as it related to their personal experiences. Mrs. Thomas is confined to a wheelchair and can do nothing for herself. (See Attachment #6) Mr. Thomas also presented a video which showed him caring for Mrs. Thomas on a daily basis.

Governor Hunt recessed the meeting at 12:10 and reconvened at 12:30 at which time, Pam Silberman, Deputy Director of the Health Planning Commission gave a federal update on health care.

Mr. Bob Berlam, Executive Director of the State Employees Association of North Carolina gave a presentation on the problems for employees of large employers as it relates to health coverage. Mr. Berlam also had two North Carolina State Correctional Officers, Mr. Robinson and Mr. McNeil, give testimony on personal experiences with regard to health coverage.

Mr. Ron Doerr of Encore Power, Inc. gave a presentation on the problems for employees of small employers as it relates to health coverage. (See Attachment #B) Mr. Doerr entertained questions from members of the commission.

Mr. Brad Adcock, Blue Cross Blue Shield, gave a presentation of the problems of securing coverage in the individual and group market as it relates to health insurance. (See Attachment #7) His presentation covered insurance coverage availability past and present.

Mr. Jim Berstein, Director of the Office of Rural Health, was recognized by Governor Hunt to give a presentation on state sponsored and federally sponsored primary care centers, health professional shortage areas, and the problems that rural and urban medically underserved areas will experience in the future. . (See attachment #8)

Dr. Arch Woodard gave a presentation on family practice in the Western part of the state from personal experience in his own practice. Discussion ensued and questions were entertained by Dr. Woodard from the Commission.

Dr. Tom Ricketts of the Cecil Shep Center for Health Services Research gave a presentation on Community Health Districts and Regionalization in North Carolina. (See Attachment #9) The Governor requested that the staff look at Community Health Districts in relation to prevention.

Governor Hunt adjourned the meeting at 3:15 p.m.

Governor James B. Hunt Jr. Chairman

Nancy Carolina Wooten, Commission Staff

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

August 23, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on August 23, 1994. Governor James B. Hunt Jr., Chairman of the Commission called the meeting to order at 9:10 a.m. A copy of the agenda is attached. Commission Members present included: Lieutenant Governor Dennis Wicker, Secretary Robin Britt, Secretary Jonathan Howes, Speaker Dan Blue, Senator Marc Basnight, Senator Beverly Perdue, Senator James Forrester, Senator George Daniel, Senator Ted Kaplan, Representative Dub Dickson, Representative Joe Mavretic, Representative Thomas Wright and Representative Richard Moore.

Governor Hunt welcomed the Commission Members and discussed the agenda, At this time, the Governor delayed consideration of the principles until all members were present for the vote.

Representative Joe Mavretic addressed the commission members and shared his thoughts with regard to universal coverage.

Dr. James G. Jones, Executive Director of the Commission, was recognized to give an overview of the work of the commission staff and consultants as it relates to the progress of the advisory committees, as well as the full commission.

Governor Hunt recognized members of the Commission who are serving as co-chairs of the Advisory Committees to give a brief status report on the work of their committee. The following members gave reports on their respective committees:

1.	Secretary Jonathan Howes	Delivery Systems
2.	Senator George Daniel	Rural and Urban Medically Underserved Areas
3.	Senator James Forrester	Quality Control
4.	Senator Ted Kaplan	Cost Containment Measures
5.	Anna Wasdell for Senator Sandy Sands	Eligibility and Enrollment
6.	Senator Beverly Perdue	Benefits
7.	Representative Dub Dickson	Health Promotion
8.	Representative Karen Gottovi	Community Health Districts
9.	Representative Joe Mavretic	Primary Care
10.	Representative Richard Moore	Insurance Reform
11.	Representative Thomas Wright	Special Populations
12.	Secretary Robin Britt	Financing
13.	Janis Curtis for Commission Jim Long	Data Collections and Information Systems.

During the presentations of the co-chairs, Representative Karen Gottovi conveyed to the members of the Commission that the Fingerlakes Health District in Rochester, New York had dramatically lowered health costs and that industry was involved in their system. She stated that this district was a good model for North Carolina to follow. Governor Hunt requested that the staff proivide the commission members with a short summary of the Rochester, New York approach to health care and a short description of the aggressive home health care in Wisconsin.

Governor Hunt asked if there were any changes to the minutes of the meeting on July 20th. Representative Thomas Wright moved for approval of the minutes and Senator Forrester seconded the motion. Motion passed and the minutes were approved.

Representative Dub Dickson moved for consideration of the Principles of the Commission. Motion passed. Representative Gottovi requested an amendment to the principles with regard to medical liability reform and moved for approval. Senator Perdue seconded the motion and the motion passed. (See attachments #1, #1a and #1b)

Governor Hunt recessed the meeting at 12:10 so Commission Members could get their lunch and bring it back to the committee room to resume working. The meeting reconvened at 12:45.

Mr. John Sheils, Vice-President of Lewin-VHI, Inc.who is under contract to the Commission, was recognized to present alternative approaches to financing universal insurance coverage. (See attachment #2)

Pam Silberman, Deputy Director of the Health Planning Commission gave a brief overview of the mainstream proposals on federal health reform.

Governor Hunt recognized Chris Conover of Duke University, who gave an overview of overall health spending - the history and the future. (See Attachment #3)

Dr. Sandra Greene, Senior Director for Blue Cross and Blue Shield of North Carolina and consultant to the Commission, gave a presentation on trends in North Carolina health care costs and utilization. (See Attachment #4)

Mr. David DeVries, Director of the State Employees Health Plan presented a breakdown of spending by the state employees' health plan, along with Mr. Paul Perruzi, Deputy Director for the Division of Medical Assistance. (See Attachment #5 and #5a)

Mr. Moses Carey, President of the North Carolina Association of County Commissioners and Mr. Ron Aycock, Executive Director of the Association gave a breakdown on spending by county governments on health related expenses. (See attachment #6)

Mr. Ches Gwinn, Senior Vice-President of Compensation and Benefits for First Union gave perspectives of the large employers on "Health Care Reform in North Carolina." (See Attachment #7)

Ms. Patricia Pleasants, Executive Director of NFIB and Frank Goodnight, President & CEO of Diversified Graphics, Inc. gave a presentation on the perspective of small employers on health reform.

Mr. Oscar Smith of Reidsville, NC presented personal testimony with regard to health insurance costs for his family. (See attachment #8)

Mr. Daniel Minchenko of Louisburg, NC gave personal testimony regarding his recent move from Vermont and his insurance coverage for his family.

Governor Hunt adjourned the meeting at 4:15 p.m. and announced that the following meeting will be on September 22, 1994 in Room 643 of the Legislative Office Building.

Governor James B. Hunt Jr., Chairman

Nancy Carolyn Wooten, Commission Staff

NOTE: For copies of attachments mentioned in the minutes, please contact the individual presenters directly at the telephone number provided on the agenda.

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

September 22, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on September 22, 1994. Governor James B. Hunt Jr., Chairman of the Commission, called the meeting to order at 9:15 a.m. A copy of the agenda is attached. Commission Members present included: Lieutenant Governor Dennis Wicker, Secretary Robin Britt, Secretary Jonathan Howes, Speaker Dan Blue, Senator Marc Basnight, Senator Beverly Perdue, Senator James Forrester, Senator Sandy Sands, Representative Dub Dickson, Representative Joe Mavretic, Representative Thomas Wright and Representative Karen Gottovi and Representative Richard Moore.

Governor Hunt welcomed the Commission Members and discussed the agenda. At this time, Governor Hunt made his opening remarks directing the commission to press toward the goal of tending to the health needs of the citizens of North Carolina. The Governor asked for discussion of and approval of the minutes of the previous meeting. Representative Joe Mavretic moved to approve the minutes, the motion was seconded by Representative Dickson and the motion passed.

Governor Hunt recognized Senator Beverly Perdue to give the report of the Benefits Advisory Committee. (See Attachment #1) Senator Perdue introduced the members of the committee and the subcommittee co-chairs, after which she presented the findings of the Benefits Committee. Much discussion ensued and questions were entertained by Senator Perdue. Also, during this presentation, Mr. Ron Bachman , an actuary with Coopers and Lybrand gave the actuarial report. (See attachment #2) Senator Perdue presented the choices of benefits options as proposed by the Benefits Committee. (See attachment #3) Much discussion ensued. Commission members felt uncomfortable adopting a specific benefits plan at this time without hearing from the Financing Committee about how the packages would be financed. The Commission failed to "adopt" a specific plan; however, it did pass a motion made by Senator Sands that the work of the Commission specifically in regards to financial modeling would move forward based on the intermediate package. (See attachment #3a)

Before the lunch break, Barbara Matula, Director of the Medical Assistance Division of the Department of Human Resources gave a presentation on her trip to the United Kingdom sponsored by the Duke Endowment.

Senator Sandy Sands, Chairman of the Subcommittee on Eligibility and Enrollment, was recognized by Governor Hunt to give a presentation of the report of this

subcommittee. (See attachments #4 and 4a) Discussion ensued and questions were entertained by Senator Sands.

Governor Hunt recognized Dr. James G. Jones, Executive Director of the Health Planning Commission who introduced Chris Johnson, the Health Policy Analyst who replaced Laura Petrou on the Commission Staff.

At this time, Governor Hunt recognized Pam Silberman, Deputy Director of the Health Planning Commission who gave a brief update on federal legislation.

Governor Hunt adjourned the meeting at 2:20 p.m.

Governor James B. Hunt Jr., Chairman

Nancy Carolyn Wooten, Commission Staff

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

October 13, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on October 13, 1994. Governor James B. Hunt Jr., Chairman of the Commission, called the meeting to order at 9:10 a.m. A copy of the agenda is attached. Commission Members present included: Secretary Robin Britt, Senator Marc Basnight, Senator James Forrester, Representative Dub Dickson, Representative Joe Mavretic, Representative Karen Gottovi, and Representative Thomas Wright.

Governor Hunt welcomed the Commission Members and discussed the agenda. At this time, Governor Hunt requested discussion of the minutes of the previous meeting, at which time, Senator Forrester moved for approval of the minutes. There was no discussion and the motion passed.

The Governor recognized Dr. James G. Jones, Executive Director of the Commission to give his usual update of the progress of the Commission.

Representative Joe Mavretic asked the Governor to request the Commission Staff to begin to send the draft reports of the advisory committees to the staff of the General Assembly so that drafts of proposed legislation could be done before the General Assembly convenes in 1995. Governor Hunt agreed that this would help ensure the Commission's deadline for submitting a proposal to the General Assembly and instructed the staff to comply with Representative Mavretic's request.

Mr. Lanty Smith, Co-chair of the Advisory Subcommittee on Cost Containment made a presentation of the interim report of this subcommittee. (See attachment #1) Mr. Smith entertained questions from members after his presentation. The Governor recognized Mr. Tom Jacks, a Health Analyst for the Commission, who gave a presentation on the recommendations of cost containment measures. (See attachment #2 and #2a).

Representative Mavretic had a handout given to the Commission Members on medical malpractice and practice environment. (See attachment #3)

At this time, Governor Hunt stated that his goal for North Carolina was universal coverage and that the Commission was moving in that direction.

Governor Hunt recognized Representative Karen Gottovi, Co-chair of the Advisory Committee on Community Health Districts, who introduced Dr. Gorden

DeFriese, Director of the Cecil Shepp Center for Health Services Research. Dr. DeFriese gave a presentation on the recommendations of this subcommittee. (See attachment #4)

The Governor recessed the meeting at 12:30 so that Commission Members could get their lunch and return to their seats to work. The meeting reconvened at 12:50.

Mr. Dave McRae, President and CEO of Pitt County Memorial Hospital gave a presentation of the interim report of the Delivery Systems advisory committee, explaining the committee process, strengths and weaknesses of the three universal coverage models and explained the committee's next steps. Chris Conover, Consultant to the Health Planning Committee gave an explanation of the three models studied by the committee - single payer, managed competition and market reform. (See attachments #5 and 5a)

Governor Hunt recognized Mr. Jim Bernstein, Director of the Office of Rural Health, who gave a presentation on the preliminary report of the advisory committee on Rural and Urban Medically Underserved Areas. (See attachment #6 and 6a)

Representative Dub Dickson , Co-chair , was recognized by the Governor to give a presentation on the interim report of the advisory committee on Health Promotion, Disease Prevention and the Role of Public Health. Representative Dickson thanked the committee members for their hard work and presented his portion of the report. (See attachment #7) Ms. Cherry Beasley, Co-chair to this committee, finished presenting the report of the committee. (See attachment #7a) Governor Hunt questioned Representative Dickson and Ms. Beasley about their opinions of the report on the Community Health Districts as it related to the work of their committee. Much discussion ensued between members of the commission and the Co-chairs of both Community Health Districts (Gottovi) and Health Promotion, Disease Prevention and the Role of Public Health (Dickson and Beasley). Representative Gottovi suggested that the co-chairs of these two committees meet in the near future to discuss the recommendation of the two committees.

Governor Hunt requested that the Commission Staff gather information about services in the 100 counties for the uninsured poor, specifically where their primary care is delivered.

Governor Hunt adjourned the meeting at 3:00 p.m.

Governor James B. Hunt Jr., Chairman

Nancy Carolyn Wooten, Commission Staff

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

November 10, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on November 10, 1994. Governor James B. Hunt Jr., Chairman of the Commission, called the meeting to order at 9:10 a.m. A copy of the agenda is attached. Commission members present included: Lieutenant Governor Dennis Wicker, Secretary Robin Britt, Secretary Jonathan Howes, Senator Beverly Perdue, Senator James Forrester, Senator Ted Kaplan, Senator George Daniel, Senator Sandy Sands, Representative Karen Gottovi, Representative Joe Mavretic, Representative Dub Dickson, Representative Richard Moore, Representative Thomas Wright, and Speaker Dan Blue.

The Governor welcomed members of the Commission and made a proposal to have a meeting retreat in early January or late December. Discussion ensued and the Commission members agreed to this proposal. Governor Hunt requested that Dr. Jones and the commission staff begin to make plans for this meeting.

Representative Joe Mavretic questioned the legality of whether members of the commission who would not be members of the General Assembly after December 31st could continue to serve on this commission. Governor Hunt directed staff to research this question.

Governor Hunt requested discussion of the minutes of the previous meeting, at which time, Senator Ted Kaplan moved for approval of the minutes. Representative Joe Mavretic seconded this motion and the motion passed.

Governor Hunt recognized Dr. James Jones, Executive Director of the Commission to present his report. Dr. Jones thanked the commission members for their work on behalf of the staff and discussed the continuing importance of health care reform.

Secretary Howes, Co-Chairman of the Advisory Committee on Delivery Systems was recognized to present a report on this subcommittee. Secretary Howes introduced committee members who were present and this made this presentation. Mr. Chris Conover, consultant to the commission, presented a portion of this report, as did Mr. Dave McRae, Co-chairman of this committee. (See attachments #1, 1a, 1b, 1c, 1d, and 1e.)

Representative Karen Gottovi requested an opinion of the commission on the creation on a State Department of Health. Secretary Howes explained that the advisory

committee on Delivery Systems did not focus on this question. He did stated it was his personal view that this would have to be addressed by the commission.

Representative Joe Mavretic requested information as to whether it was feasible for private citizens to be included on the State Health Plan. Governor Hunt directed staff to research this information. Discussion ensued reference Medicaid savings and not using savings to cover the underinsured.

Governor Hunt recessed the meeting at 9:50 and reconvened at 10:05 a.m.

Senator George Daniel, Co-chairman of the Advisory Committee on Rural and Urban Medically Underserved Areas, introduced his co-chair, Mr. Jim Bernstein, Director of the Office of Rural Health. to present the report of this subcommittee. (See attachments #2, 2a, 2b, and 2c.) Governor Hunt requested Mr. Berstein and the commission staff to provide information on primary care access in North Carolina. The Governor also requested staff to check into waiving rules to allow regulated transportation (school buses, taxis, etc.) to transport citizens to health providers. Also discussion ensued with regard to using school facilities, when not in use for education, as facilities to house health providers to the public.

Governor Hunt recessed the commission meeting for lunch at 12:10. Speaker Blue, Vice-Chairman of the Commission, reconvened the commission meeting at 1:00 p.m.

Representative Dub Dickson, Co-chairman on the Advisory Committee on Health Promotion, Disease Prevention and the Role of Public Health, was recognized by Governor Hunt to present the report of this subcommittee. Representative Dickson introduced Dr. Ron Levine, State Health Director, to present the report that his Co-Chair Cherry Beasley was to present. Ms. Beasley has a personal emergency and could not be at the meeting. (See attachments #3, 3a, 3b, and 3c)

Representative Mavretic posed a question with regard to health and school lunches and nutritional quality for the state's young people. He also requested a graph or money information from Dr. Tom Ricketts, consultant to the commission from the Cecil Sheps Center for Health Services Research about the money spent on prevention in the public health sector.

Governor Hunt recognized Representative Karen Gottovi, Co-Chair of the Advisory committee on Community Health Districts to present the report of this

committee. Representative Gottovi introduced the members of her committee who were present and thanked them for their hard work. Representative Gottovi introduced Dr. Tom Ricketts, who also helped present this report. (See attachment #4, 4a and 4b)

Representative Joe Mavretic questioned the recommendations of the subcommittee on Community Health Districts and stated that the minutes of the subcommittee meetings did not suggest "anything like regional health districts until the very last meeting", which he suggested was being pushed by the staff. Representative Mavretic stated that regional health districts had a similarity to health planning regions which was a failed concept in the 1980's. Representative Mavretic passed out a handout (Health Care 99) to the commission showing a nine county effort to solve local health problems. This handout was produced by the Fayetteville Area Health Education Center. (See attachment #5) Senator Forrester moved that the report be accepted, motion passed.

Speaker Blue adjourned the meeting at 3:20 p.m.

Governor James B. Hunt Jr., Chairman

Nancy Carolyn Wooten

Nancy Carolyn Wooten, Commission Staff

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

NOVEMBER 29, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on November 29, 1994. Governor James B. Hunt Jr., Chairman of the Commission, called the meeting to order at 9:10 a.m. A copy of the agenda is attached. Commission members present included: Lieutenant Governor Dennis Wicker, Secretary Robin Britt, Secretary Jonathan Howes, Senator Beverly Perdue, Senator Sandy Sands, Senator George Daniel, Representative Karen Gottovi, Representative Dub Dickson, Representative Joe Mavretic, Representative Thomas Wright, Representative Richard Moore and Speaker Dan Blue.

The Governor welcomed members of the Commission. Governor Hunt requested discussion of the minutes of the previous meeting, at which time, Representative Dub Dickson moved for adoption. Representative Joe Mavretic seconded the motion and the motion passed.

Dr. James Jones, Executive Director of the Commission was called on to present this report on the status of the commission work.

Representative Joe Mavretic addressed the Commission members and stated that North Carolina is on track with its health care planning and passed out information to the members and staff. (See attachment #1)

Governor Hunt introduced Mr. Marvin Dorman, State Budget Officer, who gave a description of stated budget trends in health care expenditures. Discussion ensued. (See attachment #2)

Representative Karen Gottovi requested a breakdown of information on long term care in North Carolina. Senator Sands requested a breakdown for this information by county as it related to smoking statistics. Staff was directed to provide this information.

Mr. Charles Owen III, Co-Chair of the Advisory Committee on Financing, was recognized to present the preliminary report of that subcommittee. Secretary Robin Britt, Co-Chair of the advisory committee and Mr. Chris Conover, Consultant to the Commission, also made presentation regarding the Financing report. (See attachments #3, 3a, and 3b)

Governor Hunt introduced Mr. David Manning, the Commissioner for Finance Administration from Tennessee, who gave a presentation on "Tenn-Care", the health reform plan passed by the Tennessee legislature. The Commission members questioned Commissioner Manning and much discussion ensued.

Representative Thomas Wright, Co-chair of the Advisory Commission on Special Populations, was recognized by Governor Hunt to present the final report of that subcommittee. Ms. Jane Perkins, Co-Chair of the Subcommittee, also made a presentation on the Medicaid and Civil Rights portion of the report. (See attachment #4)

Mr. Tom Jacks, Health Policy Analyst for the Commission made a presentation of the final report of the Advisory Committee on Cost Containment in the absence of the Co-chairs, Mr. Lanty Smith and Senator Ted Kaplan. (See attachment #5, 5a and 5b).

Governor Hunt adjourned the meeting at 3:45 p.m. after announcing that the next meeting would be on December 13th in Room 544 of the Legislative Office Building.

Governor James B. Hunt Jr., Chairman

Nancy Carolyn Wooten, Commission Staff

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

DECEMBER 13, 1994

The North Carolina Health Planning Commission met in Room 544 of the Legislative Office Building on December 13, 1994. Speaker of the House, Dan Blue, Vice-Chairman of the Commission called the meeting to order at 9:15 A.M. Governor James B. Hunt Jr., Chairman, joined the Commission meeting later in the morning. Commission members present included: Secretary Robin Britt, Secretary Jonathan Howes, Senator Beverly Perdue, Senator James Forrester, Senator George Daniel, Senator Sandy Sands, Representative Joe Mavretic, Representative Thomas Wright, Representative Dub Dickson, Representative Karen Gottovi, and Representative Richard Moore. A copy of the agenda is attached.

Speaker Blue welcomed members of the Commission and guests. Speaker Blue requested discussion of the minutes of the previous meeting, at which time, Representative Dub Dickson moved that the minutes be approved. Representative Mavretic seconded the motion and the motion passed.

The Speaker announced that after researching the issue of whether the members of the Health Planning Commission would remain on the commission after December 31st, it was learned that the present members would no longer be eligible to serve on the commission after this date. Speaker Blue stated that he hoped the commission members could reach a consensus on items the commission feels strongly about to be included in the bill that is to be drafted for consideration by the 1995 General Assembly.

Speaker Blue recognized Dr. James G. Jones, Executive Director of the Commission to present the report on the status of the commission work. Dr. Jones thanked the advisory committee members, the commission members , the consultants and the staff for their hard work. He stated that while universal coverage may not be possible at this time, he hoped that it would be possible to craft a master plan that would provide health care for all North Carolinians.

Dr. Frank Leak, Co-Chair of the Advisory Committee on Primary Care was recognized to present part of the report and recommendations of the subcommittee. Dr. Leak presented a handout which gave the definition of primary care. Representative Joe Mavretic, Co-Chair of this committee also presented the findings of the group. Much discussion ensued with regard to primary care physicians and providers, the insurance industry and reimbursement for the physicians. (See attachments #1 and 1a)

Representative Richard Moore, Co-chair of the advisory committee on Insurance Reform. Co-Chairman Paul Pulley was unable to attend this meeting. Representative Moore thanked the advisory committee members, consultants and staff for their work. (See attachment #2)

Speaker Blue called on Secretary Robin Britt, Co-Chair of the advisory committee on Financing to present the report of that committee. Co-chair Charles Owen was also on hand for the presentation of this report. (See attachment #3) Representative Mavretic objected to the initial comments that North Carolina cannot provide the needed health care for the uninsured or underinsured without additional money. To support his objection, Representative Mavretic said: "The commission consultants have estimated North Carolina's total expenditure for health in 1993 to be $21 billion. Using a state population estimate of 7 million, this equates to an average per capita expenditure of $3,000. Using the worst case scenario of 1.4 million North Carolinians who are either uninsured or underinsured, this equates to $4. 2 billion at the $3,000 per capita rate. The most conservative estimate of waste and inefficiencies in the current health system is 25%. In North Carolina, this equates to 25% times $21 billion or $5.2 billion which exceeds the worst case cost for uninsured and underinsured North Carolinians. The only reasonable conclusion is that North Carolinians are contributing enough for health. Their dollars are simply not being wisely used."

Speaker Blue recognized Senator James Forrester , Co-chair of the advisory committee on Quality Controls who presented the recommendations of that committee. Dr. Tim Garson, Co-chair also presented recommendations. Both Co-chairs thanked the committee members and staff for their work. (See attachment # 4 and #4a)

Insurance Commissioner Jim Long, Co-chair of the advisory committee on Data Collection was recognized by Speaker Blue to present the recommendations of the committee. Commissioner Long introduced and thanked the members of the advisory committee, consultants and staff. Commissioner Long introduced Ms. Janis Curtis, Co-chair of the committee to present the details of the report. (See attachment $#5 and #5a).

Senator Sandy Sands, Co-Chair of the advisory committee on Eligibility and Enrollment was recognized by Speaker Blue to present the recommendation of this committee. (See attachment #6)

Speaker Blue adjourned the meeting at 3:00 p.m.

Speaker Dan Blue, Vice-Chairman

Nancy Carolyn Wooten, Commission Staff

MINUTES

NORTH CAROLINA HEALTH PLANNING COMMISSION

December 21, 1994

The North Carolina Health Planning Commission met in Room 643 of the Legislative Office Building on December 21, 1994. Governor James B. Hunt Jr., Chairman, called the meeting to order at 9:15 a.m. Commission members present included Senator Marc Basnight, Speaker Dan Blue, Senator James Forrester, Senator Sandy Sands, Senator Beverly Perdue, Senator George Daniel, Senator Ted Kaplan, Representative Karen Gottovi, Representative Joe Mavretic, Representative Dub Dickson, Representative Thomas Wright , Secretary Jonathan Howes and Secretary Robin Britt. A copy of the agenda is attached.

Governor Hunt welcomed members of the Commission to the last scheduled meeting of the Health Planning Commission and thanked them as well as the Commission staff for their hard work during the past year. Governor Hunt requested discussion of the minutes of the previous meeting and Representative Joe Mavretic moved for approval of the minutes. Senator Kaplan seconded the motion and the minutes were approved.

Governor Hunt recognized Dr. James G. Jones, Executive Director of the Commission, to present the final report draft. Dr. Jones also thanked the Commission members and staff for their hard work during the crafting of the health care recommendations for North Carolina. Senator Ted Kaplan moved to adopt this final draft report for consideration and availability for changes by the Commission. Representative Mavretic seconded this motion and motion passed. Representative Mavretic moved to adopt the final report. Governor Hunt proposed that the Commission consider the final report and then go through the recommendations, flag items of concern, consider unflagged items as a consent agenda and then return to debate the flagged items. (See attachment #1) Senator Sandy Sands presented an errata sheet correcting information in the Eligibility and Enrollment portion of the report on page 49. (See attachment #1a) Senator Sands stated that this errata sheet should be considered as part of the report. Representative Mavretic added this errata sheet for consideration into his motion and requested a roll call vote, which is as follows:

Senator Sands	Aye
Senator Kaplan	Aye
Senator Forrester	Aye
Representative Wright	Aye
Representative Gottovi	Aye
Representative Mavretic	Aye

Representative Dickson	Aye
Speaker Blue	Aye
Senator Basnight	Aye

The motion passed with a vote of 9 aye votes to 0 no votes and the final report was approved, as amended by Representative Mavretic.

At this time, Governor Hunt requested the Commission members to consider and debate the document on staff recommendations. (See attachment #2) Commission members were given a handout with the recommendations broken down by issue as a working document for this meeting. (See attachment #3) Members of the Commission were requested by Governor Hunt to indicate if an item needed to be flagged for discussion and that each item would then be voted on separately. Those items not flagged would then be voted on as a group. This course of action was agreed upon by Commission members.

Representative Mavretic moved that the Commission adopt the recommendations contained in the report and recommend those to the General Assembly with the exception of the flagged items. Representative Wright seconded the motion and the motion passed.

The following items were not flagged: A 2a(i-vii); A 2b(i,ii,iv); A3: B 1, B 4(b-e) B 5(a-b) B 6(a, c), B 7, B 8 (a-b): C 2(a-b), C 3(b-c), C 4(a), C 5(b: D 2(a-d), D 4: E 3: F 1(b), F 2(a).

The following is the discussion and consideration of the flagged items of the report:

Senator Sandy Sands was recognized to discuss item A 1(a-b), Expanding Coverage to the Uninsured on attachment #3. Discussion ensued about priorities of the committee on eligibility and enrollment errata sheet and the coverage of Medicaid expansion. Senator Sands stated that this subcommittee adopted a set of priorities about the order of future Medicaid expansion. He further stated that his subcommittee considered both what was important to the state and also the cost. The Commission debated the Eligibility and Enrollment Subcommittee's recommended priority list and recommended the following:

#1 Expanding infants under age of one at 200% of federal poverty guidelines
#2 Expanding elderly and disabled at 100% of FPG
#3 Expanding pregnant women post partum at 185% of FPG
#4 Expanding coverage for children ages one through five at 185% FPG
#5 Expanding coverage for children ages one through five at 200% of FPG

#6 Expanding pregnant women coverage at 200% of FPG
#7 Expanding coverage for children ages 6-18 at 133% FPG
#8 Expanding coverage for children ages 6-18 at 185% or FPG
#9 Expanding coverage for children ages 6-18 at 200% of FPG
#10 Expanding coverage for pregnant women post partum at 200% FPG
#11 Expanding coverage for elderly and disabled at 200% FPG

Governor Hunt requested a vote of the above recommendations. Senator Sands moved for adoption of this recommendation. Motion passed.

The second flagged item considered was A 2b(iii), Guaranteed issuance; adjusted community rating, flagged by Representative Dickson. After discussion, Representative Mavretic moved that the Commission recommend individual adjusted community rating with a 5 year phase-in beginning in the year 1996 - and would not recommend guaranteed issuance. Speaker Blue seconded this motion. Motion passed and the item was adopted.

Item B 2, Controlling Rising Health Care Costs was flagged by Representative Dickson. The flag was removed after discussion and the recommendation was adopted. Malpractice Reform, Item B 3(a-g) flagged by Senator Sands was heavily discussed. Senator Sands suggested that all the recommendations not be approved with the exception of (a). Representative Gottovi moved to adopt the malpractice reform items as recommended and Senator Perdue seconded this motion. Senator Sands substituted a motion that item (a) be approved under B 3 and that (b) - (g) be deleted and that the General Assembly study the entire area of malpractice reform as a part of cost containment in the health care area. Speaker Blue seconded this motion. The motion failed. Governor Hunt entertained Representative Gottovi's motion to adopt the malpractice reform items. Motion passed and the items were adopted.

Item B 4 (a) - eliminate CON exemption for HMOs was flagged by Representative Dickson. After discussion, Senator Kaplan moved for adoption of this recommendation and Representative Mavretic seconded. Motion passed and the item was adopted.

Item B 6(b) - Provide financial incentives for sound emergency medical systems in underserved areas without full-service hospitals was flagged by Representative Wright. After discussion, Representative Wright moved for adoption of this item and Senator Forrester seconded the motion. Motion passed and the item was adopted.

Item C 1- Expanding Health Services Into Rural and Urban Medically Underserved Communities: Provide financial incentives to practice in medically underserved areas was flagged by Speaker Blue. After discussion, Senator George Daniel moved for adoption of this item and Representative Wright seconded this motion. Motion passed and the item was adopted.

Item C 2 (b)- Locum Tenens Program. After discussion, Senator Daniel moved to adopt this item and Representative Wright seconded the motion. The motion passed and the item was adopted.

Item C 3(a) - Develop new and expand existing primary care centers was flagged by Representative Dickson. After discussion, Representative Dickson moved for adoption of this item and Representative Wright seconded. Motion passed and the item was adopted.

Item C 3(d) - Waivers for Human Resource Authorities (option to amend GS 153A-77) was flagged by Representative Gottovi. After discussion, Representative Gottovi moved for adoption of this item and Senator Forrester seconded the motion. After more discussion, this item was displaced for consideration at a later time so that language could be drafted.

Item C 4(b) - Essential community provider protections was flagged by Representative Dickson. After discussion, Senator Kaplan moved for adoption of this item and Senator Forrester seconded the motion. The motion passed that the item was adopted.

Item C 5(a) - Create statutory definition of primary care was flagged by Speaker Blue. After discussion, Representative Mavretic moved to adopt this item and Representative Wright seconded the motion. Motion passed and the item was adopted.

Item C 5(c) - Developing plans to increase mid-level primary care providers was flagged by Speaker Blue. After discussion, Representative Mavretic moved to adopt this item. Representative Wright seconded the motion, the motion passed and the item was adopted.

Item C 5(d) - Encouraging collaborative practice was flagged by Senator Sands. After discussion, Senator Sands moved to adopt this item and the motion was seconded by Representative Wright. The motion passed and the item was adopted.

Item C 5(e) - Non-discrimination in insurance reimbursement against mid-level practitioners was flagged by Senator Forrester. After discussion, Senator Sands moved

for adoption of this item and Representative Gottovi seconded the motion. The motion passed and the item was adopted.

Item D 1, Improving Health Status, - Mandate that health plans cover certain preventive care services (prenatal, well child, immunizations) was flagged by Representative Dickson. After discussion, Senator Sands moved for adoption of this item and the motion was seconded by Representative Gottovi. Motion passed and the item was adopted.

Item D 2(e) - Expand safe public water supply program was flagged by Representative Dickson. After discussion, Representative Dickson moved for adoption of this item and the motion was seconded by Representative Mavretic. The motion passed and the item was adopted.

Item D 3 - Create community health districts was flagged by Senator Forrester. After discussion, Senator Forrester moved to amend the recommendations on page 25, to read "the state recommends the establishment of 6-20 community health districts" instead of "the state shall create 6-20 community health districts." This was done by unanimous consent. Senator Forrester then moved for adoption of this item and the motion was seconded by Representative Gottovi. The motion passed and the item was adopted as amended.

Item E 1, Maintaining and Enhancing Quality Care, -Establish permanent Quality Improvement Commission was flagged by Representative Dickson. Senator Kaplan moved for adoption of this item and Senator Forrester seconded the motion. The motion passed and the item was adopted.

Item E 2, Develop Report Cards to compare quality and value of different health plans or insurance carriers was flagged by Representative Dickson. After discussion, Senator Sands suggested that when the capacity becomes available, hospitals and physicians would be included in this reporting system. Representative Mavretic suggested that in order to ensure Senator Sands suggestions, on page 27 of the report under #2 in the heading that it read "Develop Report Cards to Compare the Quality and Value of Different Health Plans or Insurance Carriers and in the Long Run Hospitals and Individual Providers" instead of reading "Develop Report Cards to Compare the Quality and Value of Different Health Plans or Insurance Carriers." This was done by unanimous consent. Senator Forrester moved to adopt the item as amended and this was seconded by Representative Gottovi. Motion passed and item was adopted as amended.

Item F 1 (a-e), Expanding State's Health Information and Data Collection Capacity, Year One (FY 95-96) was flagged by Representative Dickson. After

discussion, Representative Dickson moved for adoption of these items and Speaker Blue seconded this motion. The motion passed and these items were adopted.

Item F 2(b), Implement health card standardization was flagged by Representative Wright. After discussion, Representative Wright moved for adoption of this item and Representative Dickson seconded the motion. Motion passed and this item (Year Two-FY 96-97) was adopted.

Item F 3 (a-d), Year Three (FY 97-98) was flagged by Speaker Blue. Representative Wright moved for adoption of this item and the motion was seconded by Senator Daniel. Motion passed and the item was adopted.

Item F 4(a-b), Year Four (FY 98-99) was flagged by Speaker Blue. After discussion, Representative Wright moved for approval of this item and it was seconded by Senator Daniel. Motion passed and this item was adopted.

Item F 5, Year Five (FY 99-2000) was flagged by Speaker Blue. After discussion, Representative Wright moved for approval of this item and it was seconded by Senator Daniel. Motion passed and this item was also adopted.

At this time, Representative Gottovi requested to revisit Item C 3(d) Waivers for Human Resource Authorities (option: amend GS 153A-077). Representative Gottovi moved "that staff draft legislation to allow the Department of Human Resources and the Department of Environmental Health and Natural Resources to allow counties, or multi-county consortia to form Human Resource Authorities, which can centralize funding, administration, and delivery of mental health, public health and/or social services or any combination thereof." This language would be substituted for language on page 19 of the recommendations. Senator Daniel seconded this motion. The motion passed and the item was adopted as amended.

Item G 1, Needs of Special Populations Must Be Separately Addressed, - Codify definition of special populations to be used in data collection and community health assessments was flagged by Representative Dickson. After discussion, Representative Dickson requested that the flag be removed and moved for adoption of this item and Representative Wright seconded this motion. Motion passed and this item was adopted.

Item G 2, Civil Rights Legislation was flagged by Representative Wright. After discussion, Representative Wright moved for adoption of this item and it was seconded by Senator Daniel. Motion passed and the item was adopted.

Item G 3, Enabling or support services was flagged by Representative Dickson. Representative Wright moved for adoption of this item and it was seconded by Senator Daniel. Motion passed and the item was adopted without changes.

Item H 1, Reorganization of the Commission was flagged by Senator Forrester. Senator Forrester stated that the Health Planning Commission helps educate legislative members. Senator Forrester recommended that the Commission be continued and that the Speaker and President Pro Tempore only to appoint legislators with the Commission, and obtain additional input from citizens whenever needed. After discussion, Senator Daniel moved for adoption of this item as originally recommended. Speaker Blue seconded the motion. The motion passed and the item was adopted.

Representative Mavretic was recognized and moved that the Executive Director of the Health Planning Commission be directed to work with Commission Members who are returning to the 1995-96 Assembly, the General Assembly staff, and the administration to ensure that the appropriate recommendations contained in the summary of legislation of this final report are introduced in the public bills of the 1995-96 General Assembly. Representative Wright seconded this motion. Motion passed.

Governor Hunt again thanked the Commission members for the work done during term of this Commission and wished them a happy holiday season. He also stated that the Commission could be proud of the work that was accomplished.

Governor Hunt adjourned at 12:45 p.m.

James G. Jones, MD - Executive Director

Nancy Carolyn Wooten, Commission Staff

Appendix C

Staff and Consultants

NC HEALTH PLANNING COMMISSION

STAFF

James G. Jones, M.D., Executive Director

Pam Silberman, Deputy Director, Staff to the Benefits, Delivery Systems and Quality Controls Advisory Committees

Phyllis Gray, Health Policy Analyst, Staff to the Primary, Acute and Chronic Care and Preventive Services Subcommittees to the full Benefits Committee, Health Promotion, Disease Prevention and Role of Public Health, and Special Populations Advisory Committees

Tom Jacks, a Legal/Health Policy Analyst, Staff to the Primary Care, Cost Containment, and Insurance Reform Advisory Committees

Anna Wasdell, Health Policy Analyst, Staff to the Financing, Eligibility and Enrollment, and Long Term Care Subcommittee to the Benefits Committee

Chris Johnson and Laura Petrou, Health Policy Analysts, Staff to the Data Collection, Community Health Districts, Mental Health and Substance Abuse Services Subcommittee to the Benefits Committee, and Rural and Urban Medically Underserved Areas Advisory Committees.

June Milby, Public Information Officer

CONSULTANTS

Thomas C. Ricketts, III, MPH, Ph.D., Associate Director for Health Policy Analysis, Cecil G. Sheps Center for Health Services Research and Assistant Professor of the Department of Health Policy and Administration of the UNC School of Public Health

Sandra B. Greene, Dr.P.H., Senior Director of Health Economics Research at Blue Cross and Blue Shield of North Carolina; holds a faculty appointment at the UNC School of Public Health

Christopher J. Conover, an Associate in Research at the Center for Health Policy Research and Education at Duke University.

Appendix D

Advisory Committee Members

NORTH CAROLINA HEALTH PLANNING COMMISSION
ADVISORY COMMITTEES

1. Primary Care

Co-Chairs: Rep. Joe Mavretic
Dr. Frank Leak

Staff: Tom Jacks
Consultant: Dr. Thomas C. Ricketts, Sheps Center

Members:
David Tayloe, Jr., M.D., Goldsboro
David D. Stewart, M.D., Fayetteville
Delmer "Bud" Shelton, Physician Assistant, Efland
Eugene S. Mayer, M.D., Director, NC AHEC, Chapel Hill
H. A. Easley, III, J.D., M.D., Greenville
James A. Hallock, M.D., Vice Chancellor for Health Sciences, and Dean, School of Medicine, ECU, Greenville
John T. Dees, M.D., Burgaw
Lisa L. Hamlett, Partners National Health Plans of NC, Inc., Winston-Salem
Oliver C. Johnson, Jr., Ph.D., NC Child Advocacy Institute, Raleigh
Steve Shore, Director, NC Primary Health Care Assn., Cary
Sue Sweeting, C.N.P., Public Health Dept., Blowing Rock
Lynette Y. Wilson, R.N., Neuse DD Catchment Area Team, New Bern
Harvey Estes, M.D., NC Medical Society Foundation, Raleigh
John Sullivan, President, Stanly Memorial Hospital, Albemarle
Patricia "Trish" Payne, C.N.M., M.P.H., UNC School of Nursing, Chapel Hill
Ruby Wilson, R.N., Ph.D., Assistant to Chancellor for Health Affairs, Duke University, Durham
Charles E. Blair, M.D., Weaverville
Carolyn M. Mayo, NC Health Careers Access Program, Chapel Hill

2. Rural and Urban Medically Underserved Areas

Co-Chairs: Sen. George Daniel
Jim Bernstein, NC Office of Rural Health and Resource Development

Staff: Chris Johnson
Consultant: Christine Kushner
State Staff: NC Office of Rural Health and Resource Development
Edna English, Division of Maternal and Child Health, DEHNR

Members:
E. Jackson Allison, Jr. M.D., M.P.H., Dept. of Emergency Medicine, ECU, Greenville
Thomas J. Bacon, Dr.P.H., Director, Mountain AHEC, Asheville
Charles R. Beasley, M.D., Lumberton,
Charles O. Boyette, M.D., Belhaven
Robert H. Caldwell, President, NC State Grange, Greensboro
Barbara R. Cale, Chowan Hospital, Edenton
George H.V. Cecil, Biltmore Dairy Farms, Biltmore
Gene Cochrane, Director, Hospital Div, Duke Endowment, Charlotte
Dorothy Rose "Dot" Crawford, Retired Director DSS, Franklin
Peter N. Geilich, Pres., Roanoke-Chowan Hospital, Ahoskie
Pamela Graham-Wilson, M.S.N., R.N., Wallace
John Hatch, Ph.D., UNC School of Public Health, Chapel Hill
Richard Jenks, Farmer, Apex

Thomas O. Miller, Pungo District Hospital, Belhaven
Tommy Newton, M.D., Clinton
Melvin T. Pinn, Jr., M.D., M.P.H., Neighborhood Health Center, Charlotte
Jerry Plemmons, French Broad Electric Co-op, Marshall
Evelyn "Evy" Schmidt, M.D., Lincoln Community Center, Durham
The Rev. Melvin L. Tate, Clergy, Kinston
Linda P. Yates, Consumer, Waynesville

3. Benefits

Co-Chairs: Sen. Beverly Perdue
Donald M. Hayes, M.D., Medical Director, Sara Lee Corp.

Staff: Pam Silberman
Consultant: Dr. Sandra Greene, Outside Consultants
State Staff: Theresa Shackelford, NC Dept. of Insurance

Gale Adcock, R.N., F.N.P. Manager Corporate Health Services, SAS Institute Co-Chair, Preventive Service Subcommittee, Provider Representative
John Baggett, Ph.D., Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Mental Health and Substance Abuse Subcommittee, Consumer Representative
Dan Barco, M.D., Medical Director, Aetna Life Insurance, Preventive Services Subcommittee, Insurance Representative
Marjorie Bowman, M.D., Chair, Dept. of Family Medicine, Bowman Gray School of Medicine, Co-Chair of Primary, Acute and Chronic Care Subcommittee, Provider Representative
John Burke, Burke-Taylor Associates, Co-Chair of Mental Health and Substance Abuse Subcommittee, Business Representative
Sam Cranford, President, Asheboro Hosiery Mills, Co-Chair, Preventive Services Subcommittee, Business Representative
Anne Doolen, Tri-County Health Corp., Co-Chair of Mental Health and Substance Abuse Subcommittee, Provider Representative
Ches Gwinn, Senior Vice President of Compensation and Benefits, First Union Bank, Co-Chair of Primary, Acute and Chronic Care Subcommittee, Business Representative
Gary Massey, J & G Consultants, Co-Chair, Long Term Care Subcommittee, Business Representative
DeWitt "Mac" McCarley, City Attorney, Primary, Acute and Chronic Care Subcommittee, Consumer Representative
Mary Horne Odom, Senior Tarheel Legislator, Co-Chair, Long Term Care Subcommittee, Consumer Representative
Ed O'Neil, F.S.A., M.A.A.A., Jefferson-Pilot Life, Mental Health and Substance Abuse Subcommittee, Insurance Representative
David Smith, Acturial Dept., Penn Corp Financial, Long Term Care Subcommittee, Insurance Representative
J. Craig Souza, Executive Director, NC Healthcare Facilities Assn., Long Term Care Subcommittee, Provider Representative
Gary Wilson, Senior Vice-President, Blue Cross Blue Shield, Primary, Acute and Chronic Care Subcommittee, Insurance Representative
Paula A. Wolf, Legislative Assistant/Personnel Counselor, State Employees Association of NC, Preventive Services Subcommittee, Consumer Representative

Alternates:

C. Franklin Church, M.D. Raleigh Family Physicians, Primary, Acute and Chronic Care Subcommittee
Frank James, M.D., Psychiatry Dept., ECU School of Medicine, Mental Health and Substance Abuse Subcommittee
Jasper Lewis, D.D.S., Pediatric Dentist, Primary, Acute and Chronic Care Subcommittee
George Maddox, Ph.D., Duke Center for Long Term Care Initiatives, Long Term Care Subcommittee
Jesse Meredith, M.D., Chair, Health Services Commission, Preventive Services Committee
Spurgeon Webber, D.D.S., Dentist, Preventive Services Subcommittee

A. Preventive Services

Co-Chairs: Gale B. Adcock, SAS Inst, Former Pres. NC Nurses Association
S. D. "Sam" Cranford, Jr., Businessman

Staff: Phyllis Gray
Consultant: Dr. Sandra Greene, outside consultants
State Staff: Theresa Shackelford, NC Dept. of Insurance

Members: June Conway-Alston, Twin County Rural Health Center, Hollister
Norman B. Anderson, M.D., Duke University Med. Center, Durham
Daniel H. Barco, M.D., Medical Director, Aetna, Greensboro
Barbara Ann Hughes, Ph.D., M.P.H., R.D., L.D.N., Raleigh
Jesse H. Meredith, M.D., Chair, Commission for Health Services, Winston-Salem
Robert W. Patterson, M.D., Sanford
Gwyn Pearce, Planned Parenthood, Raleigh
Sheryl J. Young, M.A., Developmental Evaluation Center, Murphy
Evalyn K. Brendel, Nutritionist, Raleigh
Spurgeon W. Webber, III, D.D.S., Charlotte
Eugene C. Hines, Jr., Lee County Health Dept., Sanford
Jack E. Kannan, Goldsboro
Paula A. Wolf, SEANC, Raleigh
Elsie Grier, Former City Council Member, Belmont
Nancy Milio, Ph.D., Chapel Hill
Robert E. "Bob" Garren, Burlington Industries, Greensboro
David Jolly, Ph.D., AIDS Training Network, Cary
Charles Robson, Jr., President & CEO, Kenan Global, Chapel Hill
Walter James, Dept. of Insurance, Raleigh

B. Primary, Acute and Chronic Care

Co-Chairs: Marjorie Bowman, M.D., M.P.A., Bowman Gray School of Medicine
Ches Gwinn, Sr. Vice President, First Union Corp.

Staff: Phyllis Gray
Consultant: Dr. Sandra Greene, outside consultants
State Staff: Theresa Shackelford, NC Dept. of Insurance

Members: C. Franklin Church, M.D., Raleigh
E. A. Lewis, Chiropractor, Greensboro
Myra J. Pratt, Physical Therapy Management, Inc., Raleigh
Gary S. Wilson, Blue Cross Blue Shield, Durham
William Gillespie, M.D., Executive Medical Director, Kaiser Permanente, Raleigh

Christopher Carney, Glaxo, Inc., RTP
DeWitt F. McCarley, Attorney, Greenville
Sara Torres, R.N., Ph.D., FAAN, Charlotte
William D. "Billy" Mills, Insurance, New Port
Wayne F. Shovelin, Gaston Memorial Hospital, Inc., Gastonia
Margaret N. McGirt, Retired Federal Employee, Waynesville
Cathy Tamsberg, Attorney, East Central Community Legal Services, Raleigh
Jasper D. Lewis, Jr., D.D.S., Greenville
David E. Yoder, Ph.D., UNC, Chapel Hill
Kevin E. McGinnis, D.C., Chiropractor, New Bern
D.C. Iverson, United Rent-All, Raleigh
Bill Mast, Mast Drug Co., Henderson
Judi Lund Person, Hospice for the Carolinas, Raleigh

C. Mental Health and Substance Abuse Services

Co-Chairs: Anne Doolen, Robeson Health Care Corp.
John Burke, Burke-Taylor EAP Consulting Firm

Staff: Chris Johnson
State Staff: Theresa Shackelford, NC Dept. of Insurance
Flo Stein, Substance Abuse Services, DMH/DD/SAS

Members: John F. Baggett, Ph.D., Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Raleigh
Lisa Barnhardt, M.S.W., Raleigh
Frank James, M.D., Psychiatry Department, ECU School of Medicine, Greenville
Richard Kosiba, NC Alliance for the Mentally Ill, Pittsboro
Laura J. Mathew, R.N., M.P.H., Psychiatric Nursing. UNC Hospitals, Chapel Hill
Harold J. May, Ph.D., Psychology Department, ECU School of Medicine, Greenville
Rose Mary Mims, Mental Health Study Commission. Raleigh
Tony Mulvihill, Alcohol/Drug Council of North Carolina, Durham
Mary Watson Nooe, Mental Health Association, Raleigh
Ed O'Neil, Senior Vice President (Group Actuary), Jefferson-Pilot Life, Greensboro
Minnie Savage, Chief of Program Services, ADATC, Greenville
Phyllis S. Sell, Assistant Vice President, Employee Benefits, Integon, Winston Salem
Robert Sipprell, Jr., Manager of Insurance Plans, Wachovia Corp., Winston-Salem
Acolia Simon-Thomas, M.S.W., Pitt County Mental Health Center, Greenville
Wanda Webb, Ph.D, Psychology Department, Davidson College, Davidson

D. Long Term Care

Co-Chairs	Mary Odom, Senior Tarheel Legislator, Wagram
	Gary R. Massey, J&G Consultants, Raleigh
Staff:	Anna Wasdell
Consultant:	Outside consultants
State Staff:	Theresa Shackelford, NC Dept. of Insurance
	Bonnie Cramer, Director, Division of Aging
	Dick Perruzzi, Deputy Director, Division of Medical Assistance
Members:	James Everest, United Cerebral Palsy, Raleigh
	Jacquelyne Johnson Jackson, Ph.D., Durham
	George L. Maddox, Ph.D, Duke Center for Long Term Care Initiatives, Durham
	Lynne M. Perrin, Asst. Secy Aging and Special Needs, DHR, Raleigh
	Jack Pleasant, Pres., NC Assn. for Home Care, Durham
	D. Allen Ray, RHA Health Services, Asheville
	David V. Smith, Vice President, Penn Corp., Raleigh
	J. Craig Souza, NC Healthcare Facilities Assn, Raleigh
	Polly Williams,Ph.D., Retired Professor NC State, Raleigh
	Lou B. Wilson (Mrs.), Rest Home Operator, Raleigh
	Angela R. Bryant, Adult Day Care Center, Rocky Mount
	Donna C. Arrington, HIV/AIDS Consortium, Charlotte
	Marlene Chasson, Consumer Advocate, Raleigh
	A. C. "Con" Starin, Senior Tar Heel Legislator, Lenoir
	Sharon D. Stiles, Administrator, Nursing Center, Gastonia

4. Health Promotion, Disease Prevention and the Role of Public Health

Co-Chairs:	Rep. Dub Dickson
	Cherry Beasley, Nurse, Pembroke State Univ.
Staff:	Phyllis Gray
State Staff:	Leslie Brown, Division of Adult Health Promotion, DEHNR
	Barry Goldstein, Division of Maternal and Child Health, DEHNR
	Linda Sewall, Division of Environmental Health, DEHNR
Members:	Melvin "Skip" Alston, County Commissioner, Greensboro
	Jim Law, Ph.D., Charlotte
	Ronald Levine, M.D., State Health Director, Raleigh
	Elaine A. Underwood, R.N., M.A., PAC Community Health, Charlotte
	Paul F. Williams, M.D., Jacksonville
	Noelle L. Kehrberg, Ph.D., Cullowhee
	Betty K. Sutton, D.D.S., Raleigh
	Howard M. Fitts, Ed.D., Retired Chair, Health Education, NCCU, Durham
	Donald D. Smith, M.D., Greensboro AHEC, Greensboro
	Robert S. "Bob" Parker, Director, New Hanover Cty Health Dept., Wilmington
	Michel A. Ibrahim, M.D., Ph.D., Dean, School of Public Health, Chapel Hill
	Alan Omar, Health Administrator, Chapel Hill
	Laureen Lopez, Ph.D., Nutritionist, Chapel Hill
	Allan Cross, M.D., Director, Center for Health Promotion and Disease Prevention, UNC, Chapel Hill

5. **Community Health Districts**

Co-Chairs:	Rep. Karen E. Gottovi
	Gordon H. DeFriese, Ph.D, Cecil Sheps Center for Health Sciences Research
Staff:	Chris Johnson
Consultant:	Dr. Tom Ricketts
State Staff:	Rick Rowe, Division of Environmental Health, DEHNR
	Judith Wright, DEHNR
Members:	James Andrews, AFL-CIO, Raleigh
	Gary O. Bean, M.D., Raleigh Family Physicians, Raleigh
	Charles Chapman, CFC & Associates, Inc., Durham
	E. Ray Cope, Kate B. Reynolds Charitable Trust, Winston-Salem
	Raul Stephen de la Vega, M.D., Gastonia
	Leah Devlin, D.D.S., MPH, Director, Wake County Health Dept., Raleigh
	Chris G. Hoke, J.D., Asst. State Health Director, Raleigh
	Richard House, Ph.D., UNC School of Public Health, Chapel Hill
	Donald L. Madison, Ph.D., UNC School of Medicine, Chapel Hill
	Chris Mansfield, Center for Health Services Research and Development, Greenville
	Jennie A. McLaurin, M.D., M.P.H., Clayton
	William C. Reeves, M.D., ECU, Greenville
	Allan Spader, NC Council of Community Programs, Raleigh
	Richard G. Sparks, CEO, Watauga Medical Center, Boone
	Maliston "Moe" Stanley, Joe and Moe's Auto Repair, Shallotte
	Vaughn Mamlin Upshaw, Association of NC Boards of Health, Pittsboro
	Kermitt N. Waddell, Attorney, Charlotte
	W. T. Williams, Jr., M.D., Carolinas Medical Center, AHEC, Charlotte

6. **Special Populations**

Co-Chairs:	Rep. Thomas Wright
	Jane Perkins, J.D., Director of the National Law Program
Staff:	Phyllis Gray
State Staff:	Tarrant Burnette, Governor's Advocacy Council for Persons with Disabilities
	Barbara Jackson, Governor's Advocacy Council for Persons with Disabilities
	Tom Vitaglione, Division of Maternal and Child Health, DEHNR
	Dennis Williams, Division of Medical Assistance, DHR
Members:	James A. Jones, Partners National Health Plans, Winston-Salem
	Lucille H. Webb, Wake County Board of Health, Raleigh
	Janice A. Freedman, First Step Campaign, Raleigh
	Karen Epp Mortimer, Dir., Caring Program for Children, Durham
	Newsom Williams, Ph.D., Psychologist, New Bern
	William W."Bill" Eller, Jr., Jefferson-Pilot Life Insurance, Greensboro
	John Mickle, Director, Community Health Coalition Project, Durham
	Olson Huff, M.D., Medical Director, The Ruth and Billy Graham Children's Health Center, Asheville
	William B. Olds, M.D., Roxboro
	W. Vance Frye, Kate B. Reynolds Charitable Trust, Winston-Salem
	Vickie Strange, Efland
	Jinnie Lowery, Health Administrator, Fairmont
	Inez M. Myles, Seniors Advocate, Henderson
	Angela M. Grimes, Chair, NAACP Health Committee, Raleigh
	Laura E. Aponte, Social Worker, Newton Grove

7. Quality Controls

Co-Chairs: Senator James S. Forrester, M.D.
Arthur Garson, Jr., M.D., M.P.H., Vice Chancellor for Health Affairs, Duke University Medical Center

Staff: Pam Silberman
State Staff: Randall H. H. Madry, Deputy Commissioner, Dept. of Insurance
Samuel Warburton, M.D., Division of Medical Assistance

Members:
Paul A. Buescher, Ph.D., State Center for Health & Envir. Statistics, Raleigh
Edward "Woody" G. Connette, Attorney, Charlotte
Linda Cozzolino, Project Associate, NC Health Access Coalition, Cary
John I. Mackowiak, Ph.D., Dir. Pharmacoeconomic Application, Glaxo, RTP
Patricia Pate, Mgr., Clinical Laboratory, Carteret General Hospital, Morehead City
Joe Vincoli, Mid-South Ins. Co, Managed Care Division, Clemmons
Calvin Michaels, Retired Dir. of Employee Benefits-Burlington Ind., Greensboro
Mary L. Snider, Physicians Health Plan, Greensboro
William M. Satterwhite, Jr., M.D., Winston-Salem
Eloise Thomas, Exec. Director, Lower Cape Fear Hospice, Wilmington
Mary Beck, Director of Planning, UNC Hospitals, Chapel Hill
Esther Watson, Director of Quality Management, Kaiser Foundation, Raleigh
Ralph E. Snyder, M.D., Director Clinical Affairs, Medical Review of NC, Raleigh
Otis B. Michael, M.D., Asheville
David Richard, Executive Director, ARC-NC, Raleigh
Suzanne Landis, M.D., M.P.H., MAHEC, Asheville
Barbara Pullen-Smith, Office of Minority Health, DEHNR, Raleigh
Cora D. Spaulding, M.D., Robert Wood Johnson Clinical Scholars Program, Chapel Hill

8. Data Collection and Information Systems

Co-Chairs: Jim Long, Commissioner of Insurance
Janis L. Curtis, Associate Chief Operating Officer, Duke Health Network

Staff: Chris Johnson
Consultant: Dr. Tom Ricketts
State Staff: Center for Geographic Information and Analysis

Members:
Tom Gold, Cone Mills Corp, Greensboro
James A. Hazelrigs, Director, NC Medical Database Commission, Raleigh
Linda M. Lacey, Associate Director, NC Center for Nursing, Raleigh
Dennis Morley, IBM Corporation, Charlotte
W. Michael Pelone, EDS Federal, Raleigh
Electra Paskett, Ph.D., Dept. of Public Health Sciences, Bowman Gray School of Medicine, Winston-Salem
Jon H. Laughter, Hendersonville
Gretchen Woeste, League of Women Voters, Charlotte
Delton Atkinson, Director, State Center for Health and Environmental Statistics, Raleigh
William D. Kalsbeek, Ph.D., Survey Research Unit, UNC School of Public Health, Chapel Hill
David J. McCombs, CEO, Moses Cone Memorial Hospital, Greensboro
Lewis Kammer, Vice President, Carolina Physicians, Morrisville
Therese G. Lawler, R.N., Ed.D., School of Nursing, Greenville
Leigh Stanton, Assistant Administrator, Blue Ridge Community Health Services, Hendersonville

Ellen Beidler, Academician, Raleigh
Jim Jones, Systems Manager, Bell South, Charlotte
Michael James, Pharmacist, Raleigh

9. Delivery Systems

Co-Chairs: Secretary Jonathan Howes, DEHNR
Dave McRae, CEO, Pitt County Memorial Hospital, Greenville

Staff: Pam Silberman
Consultants: Chris Conover, Duke Center for Health Policy Research and Education
Dr. Sandra Greene, Blue Cross Blue Shield

Members: James F. Alexander, M.D., Charlotte
Alton Anderson, M.D., Center for Adolescent and Adult Health, Weldon
Arthur Bonito, Ph.D, NC Fair Share, Research Triangle Institute, RTP
R.D. Childers, Jr., Director, Graham-Swain District Health Dept., Bryson City
Steve Cowhig, Adminstrator, Anson County Hospital, Wadesboro
C. Randolph "Randy" Ferguson, Director, Health Division, Jefferson-Pilot, Greensboro
Adele Foschia, Executive Director, Easter Seals, Raleigh
Jane Foy, M.D., Guilford County Health Dept., Greensboro
Allan K. Chrisman, M.D., Duke University Medical Center, Durham
Derek C. Gardner, M.D., Charlotte
Monica T. Hinton, Center for Improving Mountain Living, Clyde
Fred Joyner, NC Assn. of Life and Health Underwriters, Winston-Salem
Pam Kohl, Director, Planned Parenthood of the Capital and Coast, Raleigh
Anna M. Lore, Health Plan Manager, Kaiser Permanente, Raleigh
Bill Remmes, Administrator, Rural Health Group, Inc., Jackson
Deborah Steely, Project Director, NC Health Access Coalition, Cary
Paul M. Wiles, President, Carolina Medicorp, Inc., Winston-Salem
Charles C. Wilson, Director, Employee Benefits, Fieldcrest Cannon, Inc., Eden
Duncan Yaggy, Ph.D, Chief Planning Officer, Duke Health Network, Durham
Lawrence M. "Larry" Cutchin, M.D., Raleigh
Lillian R. Horne, M.D., NCCU Health Services, Durham
Kenneth C. Otis, II, CEO, Blue Cross and Blue Shield of NC, Durham

10. Cost Containment Measures

Co-Chairs: Sen. Ted Kaplan
Lanty L. Smith, CEO and Chairman, Precision Fabrics Group, Inc.

Staff: Tom Jacks
Consultants: Sandra B. Greene, Dr. P.H., Blue Cross Blue Shield of NC
Christopher J. Conover, Duke University

State Staff: C. Wake Hamrick, NC Department of Insurance
Robert J. Fitzgerald, Division of Facility Services

Members: Pam Barrett, Exec. Dir., Hospice at Greensboro, Greensboro
Robert F. Burgin, President, Memorial Mission Med. Ctr., Asheville
David G. DeVries, State Employees Health Plan, Raleigh
James Comer Gaither, M.D., Conover
Lisa K. Hux, Spring Mid-Atlantic Telecom, Wake Forest
David E. Rice, Sara Lee Corp., Winston-Salem
Charles "Chuck" Stone, SEANC Health Committee, Goldsboro
Thomas R. "Tom" Thutt, Pharmacist, Kinston

Sally Stearns, PH.D., HPAA, UNC-SPH, Chapel Hill
Wade E. Byrd, J.D., Fayetteville
Charles Highsmith, M.D., Montgomery County Commissioner, Troy
Richard L. Jones, VP Strategic Services, New Hanover Regional Med Center, Wilmington
Ted Parrish, Ph.D., Chairman, Dept. of Health Education, NCCU, Durham
Donald E. Ensley, Ph.D., ECU, Greenville
Patrick W. Dowd, Aetna Health Plans, Charlotte
Kathleen Schupner, M.D., Goldsboro
Dick Dunn, Health/Life Underwriter, Charlotte
Thomas Speros, M.D., Washington
Henry A. Landsberger, Ph.D., Chapel Hill
Calvin R. Griffin, Pres., Paperworkers Union, Roanoke Rapids
Stuart Fountain, D.D.S., Greensboro

11. Financing

Co-Chairs: Secretary Robin Britt, DHR
Charles D. Owen, III, Owen Mfg. Co.

Staff: Anna Wasdell
Consultant: Chris Conover

Members: Richard F. Baker, Westinghouse Electric, Charlotte
Patricia Pleasants, NFIB, Raleigh
Robert Schofield, NC Legal Services Resource Center, Raleigh
William C. Rustin, Jr., NC Retail Merchants Assn., Raleigh
Kelly M. Alexander, Jr., NAACP, Charlotte
Ann B. Johnson, Pres., Senior Citizens Assn., Chapel Hill
Bob Berlam, SEANC, Raleigh
Perry William Aycock, Jr., M.D., NC Society of Internal Medicine, Gastonia
Douglas D. Bradham, Ph.D., Dept. of Public Health Services, Winston-Salem
Wayne Hooper, Jackson County Board of Commissioners, Sylva
Lucy Hancock Bode, NC Medical Care Comm., Raleigh
Stephen Gary Comer, Pres., CWA, Charlotte
John W. Graeter, St. Joseph's Hospital, Asheville
Larry Churchill, Ph.D., UNC School of Medicine, Chapel Hill
Frank A. Sloan, Ph.D., Duke University Medical Center, Durham
Rose Marie Lowry-Townsend, Pres., NCAE, Raleigh
Laura Benedict, Center for Self-Help, Durham

12. Eligibility and Enrollment

Co-Chairs: Sen. A.P. "Sandy" Sands
Moses Carey, Jr., President, NC County Commissioners Assoc.

Staff: Anna Wasdell

Members: J. Michael Baker, Tri-County Community Health Center, Newton Grove
John F. Bowdish, Burroughs Wellcome Co., RTP
James A. Christian, Medical Center Director, Dept. of Veterans Affairs Medical Center, Asheville
Robert P. Doolittle, M.D, Student Health Services, Greensboro
Robert "Bob" Greczyn, Jr., Carolina Physicians Health Plan, Morrisville
Barbara D. Matula, Director, Division of Medical Assistance, Raleigh
Michael E. Matznick, Med/Flex Benefits Center, Greensboro
Christopher Scott, President, AFL-CIO, Raleigh

Dennis R. Barry, President, Moses Cone Hospital, Greensboro
F.M. "Mac" Mauney, M.D., Asheville
Jonathan D. Weston, M.D., Winston-Salem
Douglas Sea, Attorney, Legal Services, Charlotte
Devi Peterson, NC Fair Share, Raleigh
Susanne "Sandy" Moulton, Glaxo, Inc., RTP
Neil Walters, Director, Scotland DSS, Laurinburg
Dennis B. Nicks, M.D., Wilmington
Joseph G. Gordon, M.D., Winston-Salem
Lethia J. Towns, Business Owner, Burgaw
W.B. Upchurch, NC Farm Bureau Federation, Raleigh

13. Insurance Reform

Co-Chairs:	Rep. Richard H. Moore W. Paul Pulley, Jr., Attorney
Staff:	Tom Jacks
State Staff:	Allen Feezor, NC Department of Insurance C. Wake Hamrick, III, NC Departement of Insurance William K. Hale, NC Department of Insurance
Members:	Angela V. Deans, Wilson Memorial Hospital, Wilson Mark Hall, J.D., Wake Forest University School of Law, Winston-Salem J. Michael Houser, Mid-South Ins., Fayetteville Harry Kaplan, Kaiser Permanente, Raleigh Kerry E. Kilpatrick, Ph.D., Dept. of Health Policy and Admin., Chapel Hill John W. Miller, Jr., CPCU, Insurance Agent, Raleigh Connie Mullinix, R.N., M.B.A., Ph.D., Flynt Mullinix Health Care Consulting, Chapel Hill Cynthia Neloms, Personnel Director, Robeson County, Fairmont Donald J. "Don" Ottomeyer, Alex Lee, Inc., Hickory Douglas H. Bray, Jefferson-Pilot Life Insurance, Greensboro Neill H. Musselwhite, M.D., Wilmington Sheila G. McNeill, Coastal Internal Medicine and Cardiology, New Bern Kathy G. Barger, Pitt County Memorial Hospital, Greenville Eleanor L. McGinnis.R.N. Cumberland County Health Dept., Fayetteville Eric A. Buffong, M.D., Onslow Women's Health Center, Jacksonville David Wilson, Retired Insurance Executive, Morganton Bradley T. Adcock, Blue Cross Blue Shield of NC, Cary June McLaurin Jeffers, Funeral Home Director, Reidsville Mary Peeler, Executive Director, NAACP, Greensboro H. Julian Philpott, Jr., NC Farm Bureau, Raleigh

Appendix E

Summary of Advisory Committee Reports

APPENDIX E
SUMMARY OF ADVISORY COMMITTEE REPORTS

A. Benefits Committee Report - Reporting Date: September, 1994

The Benefits Committee was charged with developing recommendations about what services and other health benefits should be included in the comprehensive benefits package which would be available to all North Carolinians. Specifically, the Committee was asked to develop recommendations for a low, medium and high cost benefits package to be presented to the NC Health Planning Commission at its September 22, 1994 meeting, and to determine the level of copayments, deductibles, out-of-pocket payment maximums and lifetime maximums. The Committee was also asked to explore different methods of limiting unnecessary and inappropriate use of medical services; and to consider whether and under what circumstances supplemental benefits, above the comprehensive benefits package, could be offered.

To facilitate the work of the Benefits Committee, the staff, with the help of the Department of Insurance and Blue Cross Blue Shield of North Carolina, developed some target claims cost figures per person per month enrolled in an employer plan for each of these categories. The low cost figure of $88 per person per month was based on the most commonly purchased lower cost benefits packages; the medium cost figure of $105 per person per month was based on the average of the small group "standard" package and the most commonly purchased intermediate plans; and the high cost figure of $126 per member per month was based on the most commonly purchased comprehensive benefits package.

1. Guiding Principles:

In designing the benefits package, the Committee unanimously adopted seven guiding principles:

1. Preventive services are the cornerstone of the new health package and should not be subject to any cost sharing requirements;

2. Appropriate levels of cost sharing should be imposed on other health services; but the levels should be set to avoid creating access barriers for low and moderate income families;[1]

[1] National studies have shown that the imposition of cost sharing in health plans helps to deter the unnecessary utilization of health services. These same studies, however, showed that cost sharing also deterred the use of necessary medical services; especially among low income families. Poor children were most likely to be adversely effected by the imposition of cost sharing, and particularly deterred from the use of highly effective health services for acute conditions. Lohr, Kathleen et. al, *"Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis-and Service-specific Analyses in a Randomized Controlled*

3. Mental health and substance abuse services should be provided at a level equal to those provided to persons with other illnesses;[2]

4. Coverage of long term care services should be integrated into a comprehensive benefits package, and individuals should have the opportunity to have their needs met in the least restrictive environment;

5. "Wrap-Around" services should be provided for certain discrete and vulnerable populations; but these services should be funded through the public system;

6. The state should develop a seamless, unified health care delivery system in which the full continuum of services are integrated and delivered as needed;

7. Workers compensation health benefits should ultimately be folded into the standard benefits package.

2. Other Important Considerations:

In addition to the Guiding Principles, the Committee discussed several other issues of great importance. These included:

- The committee recommended that carriers be required to offer standardized benefits package(s), as ultimately adopted by the Commission, in order to facilitate an apples-to-apples comparison of different plans.

- The benefits package should be reviewed periodically, as our understanding of the services necessary to maintain and enhance health is constantly changing.

- A process should be established to ensure that the decision of what services are covered or excluded from the standard benefits package should be non-political, and based on the best available evidence about what services or procedures are effective in enhancing health status.

- Tort reform is needed to limit unnecessary and inappropriate use of medical care.

Trial," December 1986, R-3469-HHS; Brook, Robert et. al., *"The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment,"* December 1984, R-3055-HHS.

[2] Information provided by Coopers & Lybrand, showed that the cost of providing managed mental health and substance abuse services with a case manager in parity with other medical services only increased the cost of the benefit package by $1.20 per person per month over a more traditional limited mental health and substance abuse benefits package (with day limits on inpatient, residential and outpatient services).

3. Summary of Benefits Committee Recommendations:

The ***basic package*** includes comprehensive coverage of preventive, primary, acute and chronic care, and mental health and substance abuse services with significant cost sharing requirements: $500 deductible, 40% coinsurance, $2,900 out-of-pocket maximum. However, the first six visits to a primary care, mental health or substance abuse provider would be exempt from the deductible and coinsurance level and would only be subject to a $5 copayment (for a primary care office visit) or a $10 copayment (for a mental health or substance abuse visit). Preventive services would have no deductible or cost sharing, and mental health and substance abuse services would be offered on par with other medical services. The monthly claims cost for this package is $81.56 for a person enrolled in an employer plan, similar to the $88 per member per month claims cost for the basic package currently being sold. Average premiums, which include 15% in average administrative costs, would be: $114.96 per month for an individual; $202.04 per month for an individual with children; $221.23 per month for a couple; and $350.44 per month for a couple with children.

The ***intermediate package*** includes the same comprehensive coverage of preventive, primary, acute and chronic, and mental health and substance abuse services, but would be subject to a $250 annual deductible, 20% coinsurance, $1,250 out-of-pocket maximum. Again, there would be no cost sharing for preventive services, and mental health and substance abuse services would be offered on par with other medical services. The monthly claims cost for this package is $104.99 for an individual enrolled in an employer plan, almost identical to the $105 per member per month claims cost for an intermediate package currently being sold. Average premiums, which include 15% in average administrative costs, would be: $148.32 per month for an individual; $261.39 per month for an individual with children; $284.63 per month for a couple; and $446.40 per month for a couple with children.

The ***expansive benefits*** package includes all the same services of the intermediate package, plus long term care services. The primary, acute, chronic, mental health and substance abuse services would be subject to a $100 inpatient deductible per day (subject to a $1,000 inpatient deductible limit), a $50 outpatient visit or emergency room visit copayment (waived if admitted to the hospital), a $10 office visit copayment ($16 for after hour visits), and a $10 prescription drug copayment. In addition, the expansive package would include coverage of home- and community-based, domiciliary, and institutional long term care services (subject to a dollar limit/day). The monthly claims cost for this package is $146.32 for an individual enrolled in an employer plan, which is higher than the $126 per member per month claims cost for expansive packages currently being sold. The reason for the increased cost is largely the due to the addition of long term care services. Average premiums, which include 15% in average administrative costs, would be: $211.70 per month for an individual; $345.39 per month for an individual with children; $408.16 per month for a couple; and $589.68 per month for a couple with children.

The Committee's proposed benefits plans are premised on the Network With Choice at Point-of-Service type of delivery system, which is similar to the most commonly sold plan design in the employer-based market[3]. These plans give consumers a financial incentive to choose providers from an approved network, but allow consumers choice of any provider for a higher cost sharing arrangements, and are most commonly referred to as PPO--Preferred Provider Organizations or HMO Point-of-Service plans. These systems are approximately 15% less expensive than traditional managed indemnity plans; and therefore, provided the Committee the opportunity to offer a richer benefits package with coverage of preventive services and equal treatment for mental health and substance abuse services at an affordable cost. Further, these plans continue to offer consumers some choice of providers; as the plans allow consumers to choose any provider with higher cost sharing amounts.

[3] In North Carolina in 1993, 30 percent of the non-elderly individuals who received employer-based health insurance was enrolled in PPO plans(27.2%) or Point-of-Service plans (2.8 %). In comparison, 26 % of those with private employer-based insurance were enrolled in traditional managed indemnity plans. The trend is that more people are enrolling in network-based is that more people are enrolling in network-based care (either PPO, POS, or HMOs). Sandra Greene, Dr.P.H., presentation to Delivery System Committee, June 22,1994.

B. DELIVERY SYSTEMS - REPORTING DATE: NOVEMBER, 1994

The Delivery Systems Committee was charged with exploring different methods of assuring universal coverage and delivering health services, including but not limited to single payer, managed competition, and individual mandates. This committee was also asked to recommend methods that would ensure that everyone in the state has access to the full range of coordinated health care services, including health promotion and disease prevention, clinical preventive services, primary, acute, and chronic care services, and long term care services including home and community-based care.

The Delivery Systems Advisory Committee met on six occasions for a total of eight days. Early in the discussions, the Committee decided to evaluate three different delivery system models to ensure universal coverage: single payer, managed competition and market reform. The staff then developed three variations to consider within each of these models, for a total of nine different models. The proposals ranged from a system in which state government would provide health care services for all--to one which includes insurance reform, coupled with individual and/or employer mandates, but little other restructuring of the health system. The Committee then designed a system to evaluate the strengths and weaknesses of the different models, including a list of 50 criteria which were based on the Health Planning Commission's Guiding Principles.

The Committee used its analysis of the strengths and weaknesses of the nine models to develop three hybrid universal health care systems. These models reflect the Committee's general consensus about the best single payer, managed competition and market reform models to consider in North Carolina. The fact that a specific model is described herein should not be interpreted to mean that the majority of the Committee supported the model, since no votes were taken. Nor should the order of the presentation of the models in this report be interpreted as the order of preference, as again, no votes were taken. The Committee also developed a number of immediate reform recommendations which could be implemented immediately, as the state moves forward in its efforts to ensure universal coverage.

1. Common Themes

In designing the delivery system models, the Committee members discussed a set of common themes that were generally relevant for any delivery system. Many of the Committee's themes mirrored one or more of the Commission's principles. While the Committee tried to address all of the Commission's guiding principles, some themes kept recurring during the Committees discussions. These became the underlying policy issues which the Committee considered in developing their proposals:

a) Every resident of the state should have coverage enabling them to receive needed health services.

b) The state should balance the need for a package of comprehensive benefits with the need to control costs and prevent cost shifting.

c) The health system should ensure the delivery of high quality, coordinated health services.

d) Health care premiums and out of pocket payments should be affordable to individuals, families, businesses and the state.

e) To the extent possible, as the health care system becomes more efficient, the state should design mechanisms to capture and utilize the dollars currently in the system to meet the goals of enhancing health status and expanding coverage.

f) Health insurance carriers, health plans, public and private providers have a responsibility to help address community health priorities.

2. Summary of Delivery Systems Recommendations for Universal Coverage

Single Payer Model - The single payer model provides universal coverage through a combination of single payer with managed competition. It is based on a model which gives all state residents a choice of a fee-for-service system or competing capitated health plans. The proposal controls costs through global budgets, maximizes patient choice of providers, provides choice of plans and allows providers and facilities to remain private and economically independent. It relies on the State Employees Health Plan (or a newly created authority) to administer the plan. Employers and consumers would finance the plan through dedicated taxes instead of through premiums and deductibles.

Managed Competition Model - The managed competition model would ensure universal coverage through some type of mandate. The state would establish regional purchasing alliances. All employers of under 50 would be required to obtain health insurance through the alliance(s). Other employers would be required to provide health insurance directly to their employees. Subsidies would be provided to make health insurance affordable to those otherwise unable to afford coverage. Costs would be controlled by encouraging meaningful price competition among plans. Health plans that participated in the Alliances would be required to offer at least a standardized health plan. Consumers would be given information comparing the prices and quality of services offered in the plan. Consumers would also have a financial incentive to choose the lowest (or among the lower cost) plans, by having to pay the difference between the lowest cost plan and their chosen plan out of pocket.

Market Reform Model - The market reform model builds on the existing delivery system. It preserves the private market through which most of North Carolina residents receive insurance coverage and access medical care, and builds on this system to provide coverage for a common set of benefits to all North Carolina residents. Initially, the state would attempt voluntary efforts to cover more of the uninsured. Tax incentives would be

provided, as available, to encourage more individuals and groups to purchase coverage. Employers who offer insurance would be required to provide more choice of plans. Insurance reforms would be implemented to increase accessibility to coverage and to facilitate portability. Alliances could be established for small employers, but if established, participation would be totally voluntary. Carriers would be required to collect and maintain for the public certain data which could be used by consumers and payers to compare the quality and cost of different plans. A public pool would be established and made available to the uninsured, with subsidies for the low income population. If after five years, the percentage of the population covered has not reached 95%, then a mandate would be imposed--unless the state developed another mechanism to ensure universal coverage.

3. Immediate Reform Recommendations:

The Delivery Systems Advisory Committee offered the following list of recommendations which were designed for immediate enactment. Implementation in 1995 would move North Carolina toward more universal coverage and the other goals of health reform. The implementation of the immediate reform package would not favor the choice of any of the three universal coverage models, or prejudice a choice among them or other possible approaches.

The Committee was split over whether to offer a series of first steps which could move the state forward in its goal of universal coverage, or a more narrowly defined incremental reform option which might be perceived as a stand-alone option for the Commission's consideration. A clear majority of the Committee supported the first steps approach, which also incorporates the "incremental reform" options as the first seven recommendations listed below:

a) *Evaluate the state's responsibilities, functions, activities and performance in health.* The state should identify all of its current responsibilities in monitoring, licensing, financing, and delivering health services, and develop a plan to ensure the coordination and integration of health services in the most efficient way, with the goal of enhancing the state's ability to set health priorities and policies that protect the interests of N.C. residents in a constantly changing health care marketplace.

b) *Develop a strategy for making the state a more prudent buyer of health services.* The state should analyze the expenditures in the State Employees Health Plan, Medicaid, Workers Compensation and the purchasing alliances for small employers to determine whether the state can become a more prudent purchaser/arranger of care.

c) *Insurance Reform.* The Committee recommended that the state continue insurance reform measures aimed at promoting portability, eliminating or limiting pre-existing waiting periods, and making insurance coverage more available to the group and non-group market. In addition, the Committee recommended that absent an immediate

ERISA waiver, that the state develop a strategy to try to obtain the cooperation of employers with self funded plans voluntarily.

d) *Expanding Coverage to More Children.* The committee specifically recommended that the state expand Medicaid eligibility initially, to include all children (birth through age 18) up to 185% of poverty, and eventually to expand coverage to all children and pregnant women. If state resources permit, the state should expand Medicaid to cover more potential eligibles.

e) *Expand Access in Medically Underserved Areas.* The state should develop mechanisms to expand access to primary care for the rural and urban medically underserved communities. One recommended method would be to require a plan that covers any part of a region to cover the entire region. The state should examine barriers to access, including licensure rules and the (potential) uses of mid-level practitioners as well as reimbursement limits.

f) *Enhance Data Collection and Reporting.* The state should move beyond collecting information focused on hospital charges, to a broader collection and analysis of health information. Health information should be collected from all providers of care, with a focus on costs, outcomes, quality measures and community health status indicators.

g) *Tort Reform.* The Committee recommended that tort reform be included in the package of overall reforms, since our tort system contributes to the practice of defensive medicine. The Committee specifically recommended that the tort system require mediation prior to litigation.

h) *Standardized Benefits.* The state should develop one or more common benefit package(s) which all carriers would be required to offer. Carriers would also be allowed to offer coverage for additional benefits, along with the standardized or common benefit packages.

i) *Choice of Providers.* The Committee recommended that the state adopt a modified "any willing provider" statute, that would require plans to contract with any providers who met credentialing standards, performance standards, and were willing to accept the plans reimbursement arrangements.

j) *Gatekeepers in Managed Care Plans.* The Committee recommended that each plan be required to have a mechanism to allow patients with extenuating circumstances to petition for different types of providers to serve as gatekeepers.

k) *Plan Performance/Standards/Accountability.* The state should establish quality thresholds which each plan should be required to meet in order to be able to offer their products anywhere in the state. The thresholds could include requirements such as: financial solvency, minimum provider:patient ratios, access standards (such as time and distance requirements or waiting times), ability to provide the full array of

services, health status and outcome measurements (such as percentage of children immunized, women receiving pap smears), etc. Plans should be specifically assessed in how well they are addressing community health priorities.

l) *Non Discrimination Provisions.* The Committee recommended that the state develop anti-discrimination provisions to ensure that plans be prohibited from discriminating against providers on the basis of race, gender, or patient caseload (i.e., providers could not be excluded because they provide services to patients with certain diseases). These same provisions should also be extended to providers, to prevent provider discrimination against patients.

m) *Simplification/Standardization.* There are opportunities to simplify the delivery system and its financing to make it more cost effective and easier to use. Ideas which the Commission should consider include: standardizing benefits and exclusions; standardizing claims forms, encounter forms, explanation of benefits ("EOBs"), etc.; standardizing the information required from providers for credentialing purposes; and encouraging electronic claims submissions and other electronic data exchanges, thereby eliminating or reducing the need for supplemental attachments.

n) *Administrative Efficiencies.* The Committee recommended that the Department of Insurance create a standard definition of costs to be included in the administrative overhead category, and that each carrier be required to publicly report the percentage of premiums attributed to medical claims versus administrative overhead for each of their insurance products.

o) *Leveling the Playing Field between Public and Private Providers.* The Committee recommended that the state modify current laws to ensure that public providers can operate under the same general requirements in the development of integrated delivery systems that apply to their private competitors.

p) *Preventing In-Migration.* The state should explore mechanisms to prevent migration of individuals with illnesses into North Carolina, if North Carolina establishes a program of universal coverage sooner than other states. Some of the ideas which the Committee discussed include: establishing residency requirements (which could be waived if an individual moves into the state for employment); or establishing a mechanism to cover only the uninsured living in North Carolina on a date certain.

C. RURAL AND URBAN MEDICALLY UNDERSERVED COMMUNITIES -- Reporting date, November, 1994

The Advisory Committee on Rural and Urban Medically Underserved Areas, was charged with assessing how health reform could become an opportunity for medically underserved communities. As its chief objective, the Committee examined ways in which state health reform could result in significantly stronger health systems for North Carolina's rural and urban residents who live in medically underserved communities.

1. Key Issues

The Committee focused on the current environment for rural and urban underserved practice and ways in which that environment was changing. Currently, rural and urban underserved practices are extremely fragile. Because they are community-based and serve smaller segments of North Carolina's population, such practices are highly sensitive to changes in the marketplace, particularly the departure of physicians and other health providers. The Committee members identified five issues as key concerns for underserved areas:

a) The maldistribution and overall shortage of primary care physicians will worsen for rural and urban underserved areas with the advent of private sector health reform. These shortages also appear in the supply of nurse practitioners, physician assistants, and certified nurse-midwives.

b) Rural and urban underserved populations lack access to preventive care and often are not reached by preventive care services.

c) Health care systems for rural and urban underserved residents are fragmented. Reimbursement systems and categorical funding patterns continue to impede greater integration of services. Patients need to have easy access to primary care and Emergency Medical Services regardless of where they live. However, rural and urban underserved populations have significant barriers to health care access--including lack of transportation, poverty, lack of insurance, illiteracy, and lack of a telephone. In particular, the state's elderly, who disproportionately make up rural populations, face rising health care costs but shrinking access as fewer physicians accept new Medicare patients.

d) The market power of unmanaged competition has the potential, in the short-term, to erode the existing fragile health infrastructure of private physicians, rural hospitals, and community-based practices in underserved areas.

e) A lack of access to quality trauma care and shortage of properly trained EMS professionals in rural communities compromises the effective delivery of emergency care for rural residents.

To address these concerns, the Committee developed a set of both short-term and long-term recommendations. Committee Members believe that after a short-term period of relatively chaotic activity, lasting approximately three to four years, health care markets will stabilize in the long-run. Thus, policies must be carefully crafted so that current inequities in the system are not institutionalized in the long-run.

2. Recommended Strategies for the Short-Term

a. ***Strategies to enhance the recruitment and retention of primary care providers.***

1) Enhance existing recruitment and retention programs and continue their focus on rural and urban underserved communities through creating a Provider Incentive Fund and a *locum tenes* network.

2) Increase Medicaid payments by 35% for individual primary care providers (based on primary care CPT codes) in rural and urban underserved areas who are not currently covered by cost-based reimbursement.

3) Develop an incentive bonus plan to enhance Medicaid reimbursement for qualifying primary care providers if they serve certain community needs.

b. ***Strategies to increase access to and delivery of preventive and public health services to rural and urban medically underserved populations.***

1) Exempt core preventive care costs from inclusion in insurance cost-sharing or deductible costs.

2) Reimburse Community Outreach Workers serving in medically underserved areas through the Medicaid system.

c. ***Strategies to decrease barriers to health care for people living in rural and urban medically underserved areas.***

1) Incentives should be put into place that lead to the development of seamless health care systems--integrated service networks--for rural and urban underserved populations.

2) Provide State funding to pay the county share of Medicaid spending, eliminating the inequities that place a higher burden of spending on counties with high proportions of poor residents, which also are often the same counties with weak tax bases.

3) Allow for full deductibility of health insurance for the self-employed on their state income tax payments.

d. ***Strategies to strengthen health care systems in rural and urban medically underserved communities.***

1) Require Health Plans or managed care companies to provide coverage for communities that are underserved as a condition of licensure for providing service in more affluent or accessible areas. Existing plans would have three years to meet this requirement.

2) Implement "essential community provider" provisions that will protect--for a limited time (three years)--rural and urban primary care providers who serve at-risk or indigent patients while providing incentives for them to form or join provider networks.

3) Build on existing capacity by expanding community-based health centers in rural and urban medically underserved areas and provide capital and operational support for the development of new centers in medically underserved areas.

3. Recommended Strategies for the Long-Term

a. ***Strategies to enhance the recruitment and retention of primary care providers.***

1) Expand primary care training and community-based training in rural and urban underserved practices to introduce students to the challenges and rewards of such practice.

2) Develop a scholarship program following a "home grown" concept, similar to the Teaching Fellows program. The program will identify and support, with shared state and community funds, qualified high school students with potential to enter health careers who will receive support in return for service in their community.

3) Expand training capacity and develop targeted policies to recruit and retain nurse practitioners, physician assistants, and certified nurse-midwives in underserved urban and rural areas.

4) Liberalize designation requirements for Health Professional Shortage Areas so that more areas qualify for incentives and benefits tied to this federal designation.

5) Enact cost-saving tort reform that protects both providers and patients and encourages providers to practice less defensive medicine.

b. ***Strategies to increase access to and delivery of preventive and public health services to rural and urban medically underserved populations.***

1) Develop creative means of providing patient education and encouraging healthy lifestyles and behaviors, particularly using various forms of media. A state fund could be established to support preventive care and health education programs.

c. Strategies to decrease barriers to health care for people living in rural and urban medically underserved areas.

1) Develop a streamlined process for providing state waivers that allow counties and multi-county consortia to form Human Resource Authorities, which can centralize funding and administration of health and social services.

2) Implement Community Health Districts so that reimbursement and funding streams are simplified for both patients and physicians.

3) Ensure representation of rural and urban underserved consumers on the governing boards of Community Health Districts.

4) Examine the adequacy of anti-trust regulations in the state to ensure that providers are able to form networks and integrated health care systems that serve community needs.

5) Use of telemedicine, through the use of telecommunications and interactive television in remote clinics at rural sites, should be part of a long-term solution to the problems of access and quality care.

6) Improve data collection systems to enable consumers to compare the quality of care at rural and urban hospitals and within health care networks.

7) Institute insurance reform to support "community rating" and a standardized benefit package.

8) Carry out a study to examine solutions to discriminatory pricing for pharmaceuticals and other problems with access to pharmaceuticals, particularly for low- and moderate-income patients and families.

9) Improve transportation systems in rural and urban underserved communities to ensure that patients can reach the services the need.

d. Strategies to strengthen health care systems in rural and urban medically underserved communities.

1) Establish a capital fund to allow rural hospitals and other institutions in underserved areas to convert their physical plants to more appropriate uses.

The Medical Care Commission bond fund must be improved to accommodate smaller, higher risk organizations.

e. Strategies to strengthen Emergency Medical Services in underserved communities.

1) Improve Emergency Medical Services in rural communities, particularly through improved training.

2) Target injuries and agricultural and environmental hazards through collaborative university programs.

3) Restructure reimbursement systems in order to provide financial incentives for sound emergency medical systems in underserved areas without full-service hospitals, including a refinement of the definition of emergency services.

North Carolina's health reform legislation is unique in that it places health status and disease prevention as top priorities of a health care system. This is a significant departure from the current medical model that focuses on the treatment of disease, a resource-heavy focus that drives up costs. Society can no longer afford to continue financing the escalating costs of the medical model. Yet health care is ultimately a local product, and the health care system should find the way of leveraging the local dollars that are spent on health care so that overall goals of health reform can be met. Local levels of health care delivery will need to change in concert with the state.

Health care reform is currently underway in the private sector. Large health plans are competing for provider resources in rural and urban underserved areas, leaving some community-based practices with even scarcer resources than before. Increasingly, it is becoming evident that vulnerable populations deserve some degree of protection during this time of transition in the health care marketplace and during the transition to universal coverage under health care reform in North Carolina.

For these reasons, state health reform represents an opportunity for rural and urban underserved communities to develop cohesive, seamless health care systems, with sound foundations in primary care, emergency services, and preventive services that will lead to universal access for all North Carolina citizens.

D. HEALTH PROMOTION, DISEASE PREVENTION AND THE ROLE OF PUBLIC HEALTH - Reporting Date: November 1994

The Voice of Prevention, was developed by the state's public health leaders in 1993. This report offers a vision for an appropriate role for the state's public health system in health reform, with emphasis on population-based, preventive public health services. The report establishes critical public health objectives, especially for health promotion and disease prevention. The Advisory Committee on Health Promotion, Disease Prevention and the Role of Public Health builds on these offerings, refines them and makes them specific to North Carolina's efforts to reform the health care system.

The Health Promotion, Disease Prevention and the Role of Public Health Advisory Committee was charged by the NC Health Planning Commission "to examine ways to improve the health status of the people in this state, and develop recommendations about the role that public health should play in health care reform. The committee specifically is charged with examining methods to involve people as partners in maintaining and improving their own health, how to promote public-private partnerships to improve health, establishing a priority list for expansion of health prevention and health promotion services and evaluating which services are most effective in reducing unhealthy lifestyles."

1. Key Points

The report of the Advisory Committee on Health Promotion, Disease Prevention and the Role of Public Health describes the core public health functions required to strengthen the ability of the public health system to protect, preserve and promote the health of the public and addresses organizational issues for consideration, with recommendations for the creation of a State Department of Health and community health districts.

The Committee's report introduces a new paradigm that shifts public health, over time away from delivering clinical medical services, (based on the Commission's principle of comprehensive, universal insurance coverage for all North Carolinians). Meanwhile the Committee contends that public health should continue to provide clinical medical services and maintain its current level of funding (local and state) for this care, until it is clear that comprehensive health reform, including universal coverage is a reality. The Committee, however, affirms the community's right to determine the extent to which public health is a provider of primary medical care services.

This report is premised on the belief that the success of health reform, particularly the success of reform to change health status, is greatly dependent on two things 1) strengthening the public health system and 2) stimulating new systems of integration among all organizations within a community whose missions have an impact on the health of the public, many of which will be neither providers of clinical services nor

traditional health departments. Central to this success is the full funding of population-based public health services.

This report describes the core public health functions required and identifies 24 priority programs/services for expansion. In addition, it addresses organizational issues for consideration, with recommendations for the creation of a State Department of Health and a new entity called local health authorities.

The Committee believes that public health must continue and expand the practice of building coalitions and collaborative relationships within communities to assist individuals select for themselves strategies that promote wellness.

Lastly, the report includes cost estimates for optimal funding of priority population-based programs/services at a cost of $272,763,200. It also sets forth an interim proposal for the funding of population based services funding at a cost of $34,775,000. In addition the Committee recommends that the state supplement those counties whose public health employees are paid below the state standard, at a cost of $4,707,012.

2. ***Recommendations***

A. CORE PUBLIC HEALTH FUNCTIONS -- The committee recommends that the role, responsibility, and authority for the public health system under health system reform, include at least the following:

1) assessment of community health status, health services and needs;

2) prevention, detection and remediation of environmental health risks;

3) monitoring the adequacy of health facilities and health providers to meet the needs of the community;

4) health data collection and evaluation to measure progress toward health outcome objectives;

5) promulgation of public health policies and regulations necessary to promote and protect the health of individuals and communities;

6) communicable disease investigation and control;

7) community education and advocacy for preventive health services;

8) provision of essential public health services for all citizens;

9) outreach to assure access to all basic health services; and

10) provision of clinical services as needed to assure primary health care for all citizens

B. STATE DEPARTMENT OF HEALTH -- The committee recommends the establishment of a cabinet level state department of health as outlined in the *Voice of Prevention,* composed of all health services and functions administered by the state, including:

1. All public health divisions and offices in DEHNR including the Division of Environmental Health and groundwater functions;

2. School health functions in the Department of Public Instruction;

3. Pesticide functions in the Department of Agriculture;

4. Health functions in the Department of Corrections;

5. Licensing functions in the Division of Radiation Protection;

6. Functions in the Division of Facility Services including the health manpower database, certificate of need, emergency medical services, facility licensing and jail health;

7. Office of Rural Health;

8. All mental health functions in DHR, including mental health hospitals, substance abuse, developmental disabilities, and management and support of area mental health authorities but excluding institutions for the mentally retarded;

9. Medical Database Commission;

10. Division of Solid Waste (including hazardous waste) in DEHNR;

11. Division of Medical Assistance; and

12. All new health functions created in health system reform, including the health care commission and the medical care financing superstructure.

C. FORMATION OF LOCAL HEALTH AUTHORITIES -- The Committee recommends that the state organize the existing system of local health departments and area mental health authorities (AMHAs) into a statewide network of area health authorities to provide core public health and mental health services. Area health authorities will ensure the availability of core public health and basic mental health services in all 100 counties. In order to make the transition to an area health authority

local governments will at least maintain funding for public health and mental health services at current levels.

D. PROVISION OF A SAFETY NET FOR CLINICAL HEALTH CARE SERVICES -- The committee recommends that funding for clinical services be maintained until universal insurance coverage is a reality. Should a local health department, thereafter, either by choice or circumstance continue to provide clinical services, these departments should be reimbursed entirely through the uniform benefits plan for the provision of these services.

G. FULL FUNDING OF CORE PREVENTIVE, COMMUNITY-BASED PUBLIC HEALTH SERVICES -- Core public health functions must be fully funded with a guaranteed and predictable source of state appropriations.

1. *LOCAL PUBLIC HEALTH SALARIES* -- Mechanisms should be developed to equalize public health salaries statewide.

2. *LOCAL HEALTH DEPARTMENT FACILITIES* -- The Committee recommends that the issue of inadequate local health department facilities by studied further.

3. *COOPERATION AND COLLABORATION* -- The Committee recommends that public health place special emphasis on coalitions, state and local, that focus on the core public health functions, including health promotion and disease prevention

E. COMMUNITY HEALTH DISTRICTS - Reporting Date: November, 1994

The Community Health Districts Advisory Committee was charged with the development of the roles and scope of community health districts as well as to make recommendations for the boundaries of districts. The language of the Jeralds-Fletcher-Ezzell Health Care Reform Act of 1993 calls for the creation of community health districts that are the primary means by which the health status of all North Carolinians will be monitored and the basis for improvement in the population's health status. The key element of this concept of community health districts is the notion that population denominators can be used to identify health status problems and to direct services and programs to meet identified needs. Another fundamental assumption is that health care delivery should be guided by and responsive to local concerns and that health care services could be coordinated at levels as close as possible to the individual through community responsive mechanisms. The concept of community health districts is new to the administration of public and private health services in the State, and the Committee reviewed various potential models for the creation of districts based on current systems in other states and proposals for districting that are being implemented in states that are reforming their health care delivery systems.

The Committee developed proposals for recommendations based upon drafts developed by the Committee's leadership which were discussed at the meetings. Members and staff from the Committee met with their counterparts in other committees to determine where the creation of Community Health Districts would overlap other committee proposals. The Committee concluded that the creation of Community Health Districts could only be considered in the context of a reformed and strengthened State Health Department and that the structure of the Districts must consider the regional structure of any new health department. The Committee twice reviewed proposed boundaries for Community Health Districts and draft recommendations and discussed these recommendations and amendments to them at open meetings. The Committee approved, by mail vote, a final set of recommendations that include:

1. Recommendations:

a) The creation of a new and more comprehensive Health Department, a small number of Regional Health Districts, and the creation of sub-regional Community Health Districts.

b) Community Health Districts are to be quasi-governmental agencies operating under the immediate administrative direction of non-elected public officials with Regional Boards accountable to State government and District Boards to local government. Regional and Community districts are to be accountable for their performance to the new Department of Health.

c) Regional Boards have an advisory responsibility in the allocation of funds by the Health Department and in the planning of health services.

d) Regional and Community Health District Boards will advise the Department of Insurance on coverage of populations in their areas.

e) The Regional and District Boards will replace the authority of local boards of health and will consolidate other health related boards and functions.

f) The Regional and District Boards will advise education and training institutions to promote locally based training.

g) The proposed boards will be representative of the communities and health delivery interests of their areas.

h) The reorganized entities and functions will be supported through existing public revenues.

i) There should be six regional health districts and community health districts to have a minimum of 100,000-300,000 population with no region having more than 2 million at the time the regions are initially defined.

F. COST CONTAINMENT - Reporting Date: November 1994

The Cost Containment Measures Advisory Committee carefully analyzed its charge when it began its efforts to identify ways to contain health care costs in the state. The Committee determined that its charge implied the responsibility to identify the major factors causing health care cost increases, generally prioritize them, and recommend viable methods to control costs arising from issues.

The Cost Containment Advisory Committee was charged with the responsibility of examining ways to control rising health care costs, including, in part: eliminating fraud and abuse, reducing administrative costs for individual providers and the overhead associated with administering the health care system, standardized utilization review procedures, eliminating inappropriate use of medical technology and certain medical procedures, greater use of preventive services, encouraging more cooperative ventures between health providers, rationing of health care services, competition, higher patient cost sharing, global budgets, health planning for capital expenditures and high technology, professional liability reform, and expanded use of living wills.

1. Background

The Committee concluded that its duty to the Commission required recommending ideas which were technically feasible, as well as those which would result in cost control in the long and/or short term. The Committee took seriously Governor Hunt's admonition that it was to analyze the issues from an objective, practical perspective, and not attempt to substitute its political judgment for that of the Commission. Accordingly, the Committee has included recommendations which are, in its view, politically difficult to achieve as well as those which can be attained more easily. Nonetheless, the Committee feels that to recommend only simple solutions to the dilemma of escalating health care costs would not be of service to the North Carolina or its citizens.

To facilitate the Committee's work, the staff and consultants developed a list of potential cost containment issues, prioritized by the amount of potential cost savings from each issue. All issues in all priorities were studied by the Committee. For each issue identified, the Committee also determined whether that matter was under consideration by another committee and what the role of the Cost Containment Measures Advisory Committee should be in addressing the issue.

2. Recommendations

A. UNHEALTHY LIFESTYLES

1) Measures, including higher taxes if necessary and advertising restrictions, should be instituted by the state to discourage the use of products, such as alcohol and tobacco, which are known to contribute to high health care costs.

2) The state should mandate that cost effective preventive services such as immunizations and prenatal care be included in all benefits packages marketed in North Carolina.

3) The state should implement a model health promotion program for state employees as a pilot demonstration for utilization by the private sector.

B. INAPPROPRIATE USE OF THE HEALTH CARE SYSTEM

1) No additional "any willing provider" mandates should be enacted.

2) Physician practice guidelines should be established by the professions, with input from consumers and medical ethicists, which, in part, triage patients appropriately and divert them from inappropriate use of inpatient settings and emergency rooms.

3) The state should proactively encourage the use of advance directives and living wills to help avoid the use of expensive, extensive and heroic intervention for treatment situations arising at the end of life and for nonterminal conditions resulting in the need for indefinite custodial care.

4) Some cost sharing should be required for all health care services in order for consumers to understand cost of services and to encourage use of health care services at appropriate points of access.

5) The General Assembly should enact legislation directing a study of health care rationing.

C. INAPPROPRIATE USE OF TECHNOLOGY

1) The General Assembly should amend the Certificate of Need laws to remove any remaining financial incentives for health care providers to overutilize medical technology, diagnostic or treatment services.

2) Practice guidelines should be utilized by providers which specify appropriate parameters for the use of technology.

D. ADMINISTRATIVE COMPLEXITY

1) The Department of Insurance should develop standard, comparative, defined benefits plans to be offered by all insurance companies and HMOs in North Carolina.

2) The Department of Insurance should require that pharmaceutical claims, like institutional, dental and individual claims, use a standard claims format.

3) All health care plans in North Carolina should be required to publish a benefits booklet and cost savings guide for their members in order to relieve the complex and onerous administrative paperwork associated with the filing and interpretation of claims.

4) Purchasing pools, similar to the small business purchasing alliances, should be made available to individuals and small groups of purchasers, e.g., some or all the employees of small employers, to reduce the high administrative costs of policies sold to such purchasers.

5) A standard Explanation of Benefits (EOB) form should be designed by the Department of Insurance for ease of interpretation by providers and consumers.

6) The North Carolina Department of Insurance should adopt standards for informing the public regarding the quality and performance of all health care plans.

7) The Department of Insurance should standardize procedures for the administration of utilization review and case management programs.

8) The Department of Insurance should adopt general standards for providers to use when reporting transactions/encounters to managed care plans.

9) The state should study whether *CONFIDENTIAL* patient health data cards (similar to a credit card) with individually unique, nontransferable personal identifiers, can serve as a step toward "paperless" medical records and a reduction of bureaucratic paperwork for consumers, providers and payers.

10) North Carolina should study the viability, on the state level, within the framework of federalism, of a single payer (private or public) health care delivery system.

E. GOVERNMENT REGULATION

1) The General Assembly should enact legislation directing the Health Planning Commission or its designee to establish health expenditure budgets for both the public and private sectors, for the current year, and for five years ahead.

2) The state should facilitate efficient mergers to lower total cost, with North Carolina providing review of potential mergers to ensure that they serve the public interest.

3) Restrictions on the creation of joint ventures by public health institutions with private health care institutions should be removed from state statutes.

4) The Certificate of Need statute should be amended to ease administration and remove outdated provisions in the following ways:

a) North Carolina should eliminate the existing statutory exemption of HMOs from the CON process.

b) Operating rooms in all locations and recovery beds in ambulatory surgery facilities should be made subject to CON review, regardless of cost.

c) "Linear accelerators" should be added to the list of items specifically requiring a CON and the statutory reference to Oncology Treatment Centers should be eliminated.

d) North Carolina should add specific items to the list of major medical equipment requiring a CON, or lower the financial threshold for major medical equipment requiring a certificate of need, rather than regulating diagnostic centers.

e) North Carolina should add specific items to the list of major medical equipment requiring a CON, or lower the financial threshold for major medical equipment requiring a certificate of need, rather than regulating diagnostic centers.

5) Legislation covering public bidding should be amended to permit the use of the construction-management approach. Public bidding laws should also be changed to allow public hospitals to develop "stockless" inventory systems which could result in substantial savings.

F. DEFENSIVE MEDICINE

1) Practice guidelines should be established by a state-sanctioned body composed of physicians, consumers and medical ethicists.

2) Attorneys' fees should be determined according to a sliding scale in order to ensure just compensation for the plaintiffs' counsel, while helping to prevent inappropriate compensation.

3) A "payment schedule" of awards for physical injury, as well as for pain and suffering, should be established and provided to juries to assist them in determining the appropriate amount of damage awards.

4) To reduce the adversarial nature of medical negligence disputes, the parties in all cases of alleged malpractice, medical negligence, etc., should be required to formally notify the court having jurisdiction of the case that they have considered utilizing alternative dispute resolution before employing the judicial litigation process to resolve the dispute.

5) Existing insurance department regulations should be amended, or a state statute enacted, to enable insurance and HMO contracts to clearly specify and enforce

requirements that when a third party causes an injury which results in financial compensation from the company to the insured party, "subrogation" is permitted and the insurer is permitted, to recoup its financial expenditure from the third party.

G. INAPPROPRIATE MIX OF PRIMARY CARE AND SPECIALIST PHYSICIANS

1) The state should establish compensation incentives to encourage physicians to serve in underserved or health professional shortage areas. North Carolina must also increase utilization, training, support and reimbursement of midlevel practitioners (nurse practitioners, physician assistants and nurse midwives) as part of a collaborative team to provide primary care.

2) The state should channel financial resources into those health professional specialties that have provider shortages, such as primary care, and away from those specialties and subspecialties in which there is an oversupply of providers.

3) North Carolina should require by statute that insurers may not refuse to provide payment to group practices owned in whole or in part by nurse practitioners, physician assistants, or certified nurse midwives who are practicing within the scope of practice specified under state statutes and who are providing services recognized as beneficial and cost-effective by recognized professional authorities.

4) The North Carolina Information Highway and other information systems allowing communication among geographically distant providers should be expanded and implemented to enable providers to practice in remote areas without feeling isolated.

H. DELAYS IN SEEKING CARE DUE TO LACK OF INSURANCE COVERAGE

1) All insurance and HMO benefits plans marketed in North Carolina should be required to cover cost effective immunization and prenatal care services.

2) Programs should be utilized to eliminate nonfinancial barriers to care.

I. EXCESSIVE PHARMACEUTICAL UTILIZATION

1) Practice guidelines should be developed and utilized by providers which include protocols for the prescribing of drugs.

2) Managed care organizations should be encouraged to include review of pharmaceutical prescribing practices as part of their utilization review programs.

3) North Carolina should encourage providers to use drug formularies and to develop and produce educational and cost information regarding pharmaceuticals for distribution to consumers.

J. LONG TERM CARE COSTS

1) North Carolina should develop coordinated "portal of entry" guidelines for all long term care facilities to be used by all state and local agencies to ensure appropriateness of admission and continued residence within such facilities.

2) North Carolina should expand the number of Community Alternative Program (CAP) slots, particularly for intermediate care facility/mentally retarded (ICF/MR) patients, as a means of reducing costs and providing less restrictive care.

3) The state should expand the use of subacute beds, or use differential rates for heavy care patients to get an appropriate match of patient needs and facility space, in order to maximize efficient use of existing long term care beds. Sufficient long term care beds, or other care alternatives, should be assured so that acute care facilities are not inappropriately used in their place.

4) The state should encourage the purchase of long term care insurance by providing protection against Medicaid "spend-down" requirements for persons who buy such insurance. In order to do this, North Carolina could exempt the amount of money paid by long term care insurance policies from the Medicaid spend-down requirements. There may be federal restrictions on such exemptions. North Carolina should consider securing authority to enact this provision.

K. EXCESS NUMBER OF HOSPITAL BEDS

1) State government should expand its efforts and its capabilities to assist the conversion of rural hospitals from inpatient care toward an enduring health care presence which is appropriate for their community.

2) The state should undertake activities that would encourage the closing of structurally inefficient hospitals and elimination of unneeded facilities.

3) The state should facilitate mergers between hospitals in which a larger hospital acquires a smaller hospital but ensures that essential services are still available in the market area of the smaller hospital and arrangements under which HMOs (or other managed care plans offered by insurers) are encouraged to expand their market area to include rural areas.

G. SPECIAL POPULATIONS - Reporting Date: November, 1994

The Advisory Committee on Special Populations was charged with examining the unique needs of special population groups, including the needs of low income, people of color, migrant and seasonal farm workers, people with disabilities, children and the elderly. This committee is also charged with examining whether Medicaid should be continued under comprehensive health reform; the need for special enabling services, such as transportation, case management services, culturally sensitive and appropriate services, removal of physical barriers for people with disabilities and other barriers which prevent special populations from accessing health care services.

1. Background

This report is premised on the belief that some individuals who are members of selected population groups face barriers to obtaining appropriate and needed health and support/enabling services. These barriers may arise because of: (1) *exceptional medical, psychological and or social conditions*; (2) *poor health status* or *perceived risk for poor health status;* (3) *access barriers to care* arising from financial, cultural, linguistic, or personal concerns emerging from issues of lifestyle, education, employment and or housing and or (4) *delivery system issues* resulting from lack of availability health care, geographic location and/or perceived or actual health system discriminations.

Almost all of these groups are found in every county and community in North Carolina. On a whole, they tend to evidence the above characteristics disproportionately to the general population. Included in these groups, *but not limited* to them are:

- racial and or ethic minorities
- migrant and seasonal farm workers
- the disabled
- undocumented aliens
- individuals at or below 200% of the federal poverty line
- the frail or vulnerable elderly, and
- uninsured and underinsured children

The report describes 13 services, called enabling or support services, that the Committee believes should be available and accessible to all individuals, but especially to the populations facing tremendous barriers to acquiring appropriate health services. As defined, these services assist an individual or family in accessing and/or maximizing the effectiveness of medical/health services. In addition, the report states that these services are of such importance that they should either be funded through the benefits plan or through government supported programs with assurance that these services be available to all future populations enfranchised into the Medicaid program.

Given the vital role played by the Medicaid program in ensuring access to health services for those most vulnerable, the report urges that as the state moves forward with health reform, no harm be done to this program. Further, the Committee contends that until there is health reform, Medicaid should continue to aggressively enfranchise populations who currently are uninsured. As a first step, the Committee recommends that Medicaid eligibility be extended to additional pregnant women, children and those North Carolinians who are aged, blind and disabled. To the extent Medicaid benefits are extended to new populations of uninsured, coverage of enabling or support services must be included as part of the benefits package.

The report also describes five discrete civil rights protections that must be part of a reformed health system. These protections include: (1) uniform prohibitions on discrimination, (2) data collection, (3) use of an "effects" test, (4) enforcement and (5) measured improvement in access and improved health status. The inclusion of these protections are based on the fact that the current, health care system remains inaccessible and inadequate for too many in this state, especially those deemed by this Committee as "special populations." Hence, it is critical that any new or reformed system account for the health status and access to the benefits of the health care system for *all* North Carolinians.

Lastly, the report also offers an interim, systematic transition to health reform that draws on the work of three advisory committees -- Benefits, Special Populations and Health Promotion, Disease Prevention and the Role of Public Health. The proposal has two primary features: (1) extension of benefits through enhanced Medicaid eligibility and (2) expansion of the capacity of existing services to provide enabling or support services.

2. Recommendations

a. Enabling or Support Services

Enabling or support services are those which assist an individual or family in accessing and/or maximizing the effectiveness of medical/health services included in the basic benefits package:

1. ENABLING OR SUPPORT SERVICES include at least the following:

- outreach
- health education/anticipatory guidance
- transportation
- respite care
- homemaker/personal assistance
- family counseling
- care coordination/case management
- support/child care while attending treatment

- interpreter/translation services
- vehicle modification
- adaptive equipment
- home modification
- parenting skills development

2. AVAILABILITY OF ENABLING SERVICES -- Enabling or support services as defined by the Committee should be available and accessible to all individuals/families, with emphasis on those special populations which have difficulties in accessing medical/health care.

3. FUNDING FOR ENABLING OR SUPPORT SERVICES -- Enabling or support services should be funded either as part of the benefits package or through government supported programs.

4. PRIORITY SERVICES -- If the entire package of enabling or support services is not funded, priorities should be established as follows:

1) Outreach, including information and referral regarding the availability of services and the rights of individuals to access them, should be available statewide through a Hotline/Health Information System.

2) Every county must designate a lead agency responsible for assuring the availability and accessibility of enabling or support services either by directly delivering or arranging for such services. This lead agency will be responsible for developing an enabling or support plan.

3) Every county's plan for enabling services must include interpreter/translator services, transportation, and care coordination for individuals who have a need for such services.

4) Other enabling services should be included in every county's plan based upon the availability of funds and priorities established within the county.

b. Medicaid

1. BASELINE FOR REFORM -- Since Medicaid is currently the major funding source for enabling of support services, Medicaid eligibility and service coverage should be a baseline below which no "reform" should go. To the extent Medicaid benefits are extended to new populations of uninsured, coverage of enabled or support services must be included as part of the benefits package.

2. ORDERLY TRANSITION TO HEALTH REFORM -- As "reform" is adopted and implemented, special care must be taken to assure an orderly transition of current Medicaid clients to the new coverage plan.

3. EXPANSION -- Until health reform is achieved, every effort should be made to aggressively expand the Medicaid program.

4. INTERIM STEPS -- As an interim step, Medicaid eligibility should be expanded to provide:

a) ambulatory care for pregnant women - post partum for 2 years up to an including those with incomes at or below 185% below the federal poverty level

b) full benefits for children aged 1-5 and including those at or below 185% of the federal poverty level

c) ambulatory care, through the Caring Program for Children ages 6-18 up to and including those at or below 185% of the federal poverty level

d) full coverage for those aged, blind and disabled at or below 100% of the federal poverty level

c. Civil Rights Protections

1. EFFECTS TEST -- Health reform legislation should include a broad, general anti-discrimination provision prohibiting all components of the system from engaging in practices that have the effect of discriminating against protected groups.

2. EQUAL ACCESS -- To ensure equal access, broad, general anti-discrimination provisions must be included in any health reform legislation prohibiting health plans, insurers and individual providers from engaging in practices that have the effect of discriminating on the basis of race, color, national origin, religion, gender, language, socio-economic status, age, sexual orientation, disability, health status, anticipated need for services affiliated with any persons or entities or mix of health professionals.

3. COLLECTION OF DATA -- Health reform legislation must provide for collection and dissemination of data on enrollment, utilization, treatment, outcome and consumer satisfaction of protected groups. This data should be computerized in a uniform, compatible format that is available to the public.

4. ENFORCEMENT POWERS -- Enforcement powers must be specified in the statutes. Aggrieved individuals and the State Attorney General must have an express right of action, with access to all appropriate remedies.

5. MEASURED ACCESS -- All health plans certified in North Carolina must be assessed and found to comply with anti-discrimination prohibitions prior to approval. As a condition of continued operation in the state and/or the continued receipt of state funds, such plans must act to meet specific, measurable objectives designed to ensure

access to covered services, timely and appropriate utilization of services and improvement in health status of protected groups.

H. PRIMARY CARE - Reporting Date: December, 1994.

The Primary Care Advisory Committee was charged with studying ways to increase the number of primary health care providers in North Carolina—both physicians and midlevel providers. The Committee was also assigned the duty to analyze changes needed in education, reimbursement, workforce planning and state appropriations to improve access to primary health care for our citizens.

The Committee sought the advice of the deans of the state's four medical schools—the University of North Carolina at Chapel Hill, East Carolina University School of Medicine, Duke University Medical Center and Bowman Gray School of Medicine. The Committee also requested advice from the deans of the Schools of Nursing at the University of North Carolina at Chapel Hill, Duke University Medical Center and East Carolina University. Leaders in primary health care delivery representing physicians, nurse practitioners, certified nurse midwives and physician assistants made in-depth presentations to the Committee regarding their professions' roles in making primary health care more available to North Carolinians.

After receiving this input and analyzing extensive material provided by staff and consultants, the Committee determined that the subject areas into which their recommendations should be grouped were: Definition of Primary Care, Education, Practice Procedures, Recruitment, Retention and Reimbursement.

1. Summary of RECOMMENDATIONS

A. Definition of Primary Care

1) A definition of primary health care should be adopted by the General Assembly, state health occupational licensure boards, health-related professional associations including the medical societies and health care provider associations. It should be based on the following definition:

> "Primary care is that health care provided by physicians, physician assistants, nurse practitioners and certified nurse midwives prepared by education, disciplinary training and experience to give it. It is health care based on a sustained relationship between the clinician and the individual seeking such care, established for the purpose of preventing injury and illness, promoting mental and physical wellness and providing early and continuing intervention in the management of acute and chronic illness.
>
> "This relationship is established with the mutual expectation of continuation over time, regardless of the individual's health state, and is predicated on the development of mutual trust and respect, a commitment by each party to the relationship and to working cooperatively to achieve the intended purposes.

"Both the clinician and the individual have responsibilities whose fulfillment is required for the relationship to be successful in achieving its purposes and to constitute primary health care.
"It is the clinician's responsibility to provide health care which is continuing, comprehensive and integrated and which is accessible to the individual, technically sound and appropriately adapted to the individual's preferences, sociocultural context, work environment, role demands and health state. Primary health care must include all of the above, not one or several.
"It is the individual's responsibility to seek continuing care directly from the primary health care provider (unless otherwise advised by the provider), to adhere to the health plan, treatment advice and referral advice discussed and agreed upon and to communicate all information needed to permit the provider to adapt plans and advice to the individual's preferences, sociocultural context, work environment, role demands and health state."

2) Each appropriate professional licensure board should develop and implement, by the year 2000, a post-licensing credentialing category called "primary health care" (physician), (nurse practitioner), (physician assistant), (certified nurse midwife), etc., which is based on the above definition, and which recognizes the capabilities and nature of primary health care, and that in order to qualify as such, professionals be judged and evaluated in accordance with this definition.

3) The Legislature should require that medical and health professional education produce physicians, physician assistants, certified nurse midwives and nurse practitioners able to satisfy the definition of primary care, and that the professional societies structure their credentialing in support of this definition.

B. Education

1) The plans required from North Carolina's public and private medical schools for increasing the number of primary health care physicians should be expanded to also include plans from the state's health professional schools regarding methods for increasing the number of midlevel primary health care providers.

2) The requirement that the Board of Governors of the University of North Carolina annually report to the General Assembly on the graduation rates and career choices of primary health care physicians should be amended to obtain: (1) similar data on midlevel primary health care providers, and (2) annual revisions to the plans prepared by the state's private and public medical and health professional schools to increase the number of physician and midlevel graduates entering primary health care careers.

3) North Carolina's state medical schools and health professional schools should reallocate existing budgets to fund the educational programs to produce more primary

health care providers—physicians, nurse practitioners, physician assistants and certified nurse midwives.

4) AHEC funding for health care education residencies, professional training, etc., should go toward those institutions which have successfully made efforts to produce primary health care providers.

5) Any state general funds going to a private medical or health professional school should be directed to fund only those departments or programs supporting primary care and producing primary health care providers, and should serve to augment and extend the capabilities of these departments or programs, and not to replace regular public or private institutional budgets for these programs.

6) The State Auditor should conduct an independent audit of North Carolina's state medical schools and health professional schools to determine if reallocation of funds, or additional funding, will be necessary, should the institutions conclude that they cannot fund these primary health care programs without additional appropriations.

7) North Carolina should develop an equitable form of state-funded payment for assisting those practice sites participating in the teaching of medical, physician assistant, nurse practitioner and certified nurse midwife students.

8) Medical schools should expand the number of primary care residencies through reallocation of current levels of state funding, through state-supported medical schools, the AHEC program and similar initiatives.

9) All high school guidance counselors should be educated regarding the need for students in health careers, the availability and variety of such programs and the educational preparation required in junior and senior high school for entry into each.

10) Greater financial assistance for promising students from underserved areas as well as underrepresented racial and ethnic groups should be developed to enable them to pursue health careers in community colleges, undergraduate, and graduate and professional school settings.

11) Financial support to North Carolina's public medical and health professional schools which are making the most successful efforts, and having the most successful outcomes, in their efforts to attract and graduate increased numbers of students from underserved areas of North Carolina and from underrepresented racial and economic groups should be increased. AHEC funding for residencies, professional training, etc., should go to those institutions producing increased numbers of minority providers.

12) North Carolina's public medical and health professional schools should enable the admission of health sciences students from community colleges by accepting

appropriate health sciences courses successfully completed in the community college setting, and/or with appropriate testing.

13) North Carolina should provide financial support to health professional schools that (1) offer outreach programs in geographic areas with high percentages of underrepresented racial and ethnic groups, and/or (2) offer courses during nontraditional and flexible hours to accommodate students with young families or daytime jobs.

14) The educational curricula of the various primary health care providers should be required to expose them to the education, training and practice activities of each other early in their professional education, and this interdisciplinary education should continue throughout their education and training. An interdisciplinary education program for primary health care physicians and midlevel providers should be initiated.

15) State funding should be provided for incentive payments to practices willing to accept primary health care students (medical, physician assistant, nurse practitioner and nurse midwife) and give preference for receipt of those funds to those primary health care practices willing to accept two or more categories of students from these professional disciplines.

16) North Carolina's schools of higher education should increase their midlevel primary health care graduates by 50% in order to produce a sufficient number of providers able to practice collaboratively.

C. Practice Procedures

a) The collaborative practice model should be encouraged as the organizational method under which primary health care will be developed for North Carolinians in the future.

b) The state, through its practice rules, licensing standards, reimbursement policies and educational programs should encourage the development of collaborative practices between and among primary care health care physicians and midlevel providers.

c) The North Carolina Chapter of the American College of Nurse Midwives, the North Carolina Nurses Association, the North Carolina Academy of Physician Assistants, and the North Carolina Medical Society should jointly develop a definition of, and rules for, collaborative practice which can be proposed to the General Assembly in its Short Session in 1996, as well as to the Board of Medical Examiners and the Board of Nursing.

d) The general statutes guiding professional corporations, which currently permit only physician-to-physician incorporation, should be amended. The law should permit

professional incorporation across professional boundaries to include those midlevel primary health care providers permitted to practice under the Medical Practice Act (physician assistants, certified nurse midwives and nurse practitioners), in order to permit corporate primary care organizations including midlevel providers and/or midlevel providers and physicians.

e) North Carolina should require, by statute, that insurers may not refuse to provide payment to practices owned in part, or in whole, by nurse practitioners, physician assistants or nurse midwives who are practicing within the scope of practice specified under North Carolina statutes and who are providing services recognized as beneficial and cost-effective by recognized professional authorities.

D. Recruitment and Retention

1) Health plans, managed care organizations and HMOs should be required to provide coverage for all urban and rural underserved communities in their authorized area of coverage as well as urban and/or affluent communities as a condition of licensure.

2) North Carolina should require that managed care organizations utilize "essential community providers" in underserved areas until suitable and qualified alternative primary care providers are in place in those areas or for three years, whichever is shorter.

3) The role and funding of the Office of Rural Health and Resource Development should be expanded to permit increased services and support in underserved areas in practice management, quality assurance, office operations and recruitment and retention of primary care providers.

4) The role of the Office of Rural Health and Resource Development should be strengthened and expanded to coordinate all aspects of primary care delivery in underserved areas by promoting the collaborative model for delivery for primary care and providing alternative solutions to delivery system issues.

5) State funding should be provided to support programs to enhance:
    - Health careers development and the minority workforce.
    - Expanded community-based education of medical students, midlevel provider students and allied health students with payment to community providers and/or community practices to offset some of the cost of teaching in the clinical setting.
    - *Locum tenens* (temporary replacement) arrangements through AHEC to assist community providers in isolated settings, particularly those who also serve as preceptors in their practices.
    - The expansion of primary care residency programs that also include a rural training component for residents (such as the East Carolina University programs at Williamston and Ahoskie).

- The development of selected rural and community health centers as interdisciplinary teaching practices that educate students from several health disciplines and medical residents in team practice.

6) State funds should be provided through the Office of Rural Health and Resource Development to develop a program matching available local funds with state resources for the purpose of allowing underserved communities in which such recruitment is feasible to recruit primary care physicians.

E. Reimbursement

1) The Medicaid program should increase primary care physicians' reimbursement rates by 20% to make them more equal to the rates paid to specialists.

2) North Carolina should enact a tax credit incentive plan for primary care providers who provide care to the Medicaid population in underserved areas.

3) The state should continue and expand its existing programs for repayment of loans associated with the professional education of primary care providers who agree to, and actually do, work in underserved areas.

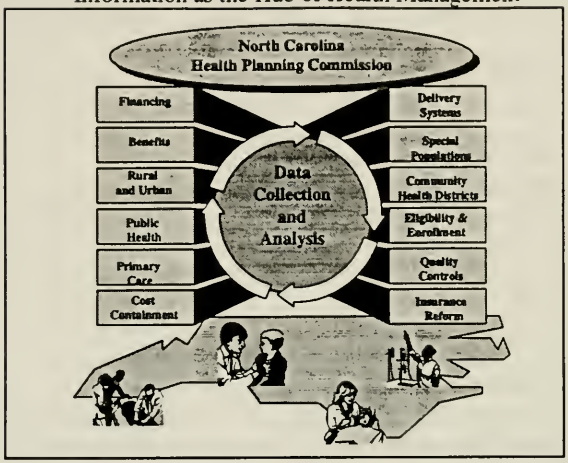
4) North Carolina should authorize reimbursement bonuses for primary care providers who care for the underserved by working in health professional shortage and medically underserved areas.

I. DATA COLLECTION AND INFORMATION SYSTEMS - Reporting Date: December, 1994

The health care system in North Carolina is undergoing rapid change. One change in particular, the movement towards a managed care environment, has generated much activity in the market. To gain control over health care costs, industry participants are affiliating in any number of ways. Integrated health delivery systems are being created, blurring the lines between payer and provider. HMO's, PPO's, PHO's and other types of organizations resulting from these affiliations are attempting to optimize the utilization of services while maintaining and improving the quality of care. At the same time, the government is concerned with improving access and coverage for those individuals who are not financially able to receive proper health care services. Greater emphasis is being given to preventive care as a means to reduce the utilization of more expensive acute care services.

The other twelve advisory committees of the Health Planning Commission represent the major functional components of the health care delivery system or major areas of concern (e.g., special populations) resulting from these changes in the health care market. As shown in the figure below, health care information is the hub around which many of the activities in these functional areas revolve. Some of these functions have unique information requirements. Many share data needs which relate to what health and medical services are being provided to whom, where, for what, by whom, who is paying the bill, and what is the outcome? This information, combined with resource data when aggregated in different ways, will fulfill 90 % of the health and medical data requirements identified by the various advisory committees comprised of representatives from the public and private sector, and identified by the public at-large.

Information as the Hub of Health Management



To improve the quality of and access to health services while at the same time contain the cost of these services to the citizens of North Carolina, policy makers and health managers will need more sophisticated information support to make effective decisions. These decisions affect resource allocation, plan performance, and the implementation of new programs to fill the gaps currently existing in the State's delivery system. To help ensure that the consumer is better informed and to facilitate the changes occurring within the market, standardized provider performance information must be collected and made available to the public. Researchers will need a broader range of detailed health data in order to identify trends and establish clinically based performance measures. Practitioners and clinicians will need more timely access to information related to patient history and current treatment.

The Committee envisions a decision support capability that will provide the capacity to (a) deliver cost effective care, and (b) effectively evaluate access to, utilization of, quality of, and cost of health care services at both the specific disease level and at the macro level for communities and sub-population groups. Baselines are needed to properly define the current levels of health system performance and to measure progress in improving that performance. This enhanced capacity for decision makers requires improved coordination of data collection among health organizations, both public and private. We must build on the strengths of the various agencies already existing for the purpose of collecting and analyzing health data.

To enable these decision support capabilities, a technical infrastructure must be put into place that takes full advantage of current technology and emerging standards. Health transaction processing must move from paper to an electronic environment to reduce the administrative costs of health care and provide the capability to properly handle the large

volumes of data associated with health management, health sciences, and clinical research. The technical infrastructure must also be an open system architecture and have the flexibility to accommodate both the current and future needs for health information.

The Committee recommends twenty-one specific actions to (1) fill identified information gaps and (2) begin creating the necessary technical infrastructure.

ASSESSMENT RECOMMENDATIONS

1. Expand current data collection and analysis to include data from all ambulatory care sites.

2 Establish a mechanism for ongoing assessment of the health status and health needs of all citizens within counties, community health districts, and other areas as appropriate.

3. Establish appropriate information gathering mechanisms to (a) monitor the level of the uninsured population and (b) examine relevant coverage and access health care issues affecting those North Carolina residents who are uninsured, underinsured, or are non-users of the state's health care delivery system.

4. Require, as a condition for licensure, all health plans operating in the State to implement a nationally recognized health plan quality assessment model which includes minimum standards for data collection regarding health care utilization, disease prevention, health promotion initiatives, and costs.

5. Modify existing statutes and regulations to require (a) the submission of medical specialty, service location, and other health service information at license renewal and (b) annual renewal for all licensed providers (professional and institutional).

6. (a) Establish legislation to provide personal control over the privacy and accuracy of patient information.
   (b) Have the Health Data Policy Council (Organizational Recommendation #1) study and provide recommendations with respect to the release of provider performance information, specifically as it relates to practice patterns and provider liability.

7. Create an on-line catalog of available public and private health data repositories, analyses, reports and ongoing research efforts to facilitate access to health information via Internet or toll free telephone access.

TECHNICAL RECOMMENDATIONS

1. Accelerate Electronic Data Interchange (EDI) implementation by requiring that claims, encounters, remittances, eligibility verifications, and other health

care related transactions be transmitted by electronic means by all health care providers, licensed insurers, managed care organizations, third party administrators, and other participants involved in the administrative processing of health care insurance and delivery transactions.

2. Require that enrollment, benefits, and eligibility transactions by payers and subsequent contractors be transmitted by electronic means.

3. Establish licensure requirements for commercial health care transaction clearinghouses for certification, appraisal, standardization, and the application of state mandated security measures to protect the confidentiality of patient information.

4. Amend enabling legislation for the Medical Database Commission to allow collection of encounter data from health care transaction clearinghouses.

5. Require (a) the use of a unique patient identifier based on Social Security Number and (b) uniform application of nationally recognized standards for the unique identification of payers, providers, employers, third party administrators and utilization review organizations.

6. Establish a state sponsored program to provide technical, educational, and implementation assistance to providers and payers to accomplish the transition to the EDI environment.

7. Require any health plan administrator who issues embossed plastic identification cards with a magnetic stripe on the reverse, to include the following information: social security number, name, address, next of kin, payer information, benefit coverage, precertification requirements, the name of third party administrators and relevant phone numbers.

8. Connect current state health data repositories to the NC Information Highway in order to form a distributed health data network for linking patient, payer, provider, and facility data sets.

9. Provide pilot project grants for three Community Health Information Networks (CHIN) in different communities of the State as demonstration projects.

10. Establish authority for the state to facilitate rural access to clearinghouse services for processing claims, encounter reports, claims status inquiry, eligibility, and other electronic data interchange transactions related to health insurance and service delivery.

ORGANIZATIONAL RECOMMENDATIONS

1. Assign responsibility to a specific state organizational body or create a new organization if appropriate, herein referred to as the Health Data Policy Council, for the specific purpose of
   (a) setting policy and establishing guidelines governing health data processing and collection and the information systems related activities in the private and public sectors consistent with the recommendations in this report, and
   (b) providing ongoing public oversight of the health data and information systems related activities necessary to accomplish the expressed goals and objectives of the North Carolina Health Planning Commission.

2. Reauthorize current staff functions of the Medical Database Commission (MDC) as a line function with expanded capabilities within the Department of Insurance and transfer the policy functions of the MDC members to the Health Data Policy Council (Organizational Recommendation #1).

3. Establish a consortium of the managers of State agencies having health data related responsibilities as a major function, to better coordinate the collection and analysis activities of those agencies.

4. Create a Clinical Task Force to advise and assist the Health Data Policy Council with the standardization, collection and use of clinical data to ensure the delivery of quality care.

These recommendations represent a comprehensive upgrading of health data collection and information systems capabilities within the State. It will be essential that they are properly planned and executed over a time frame that allows participants to become vested in the transition and to make the technical adaptations necessary for successful implementation. These recommendations constitute the basis for development of a five year plan for improvement in North Carolina's health assessment and decision support capabilities.

J. QUALITY CONTROLS - Reporting Date: December, 1994

The Quality Controls Advisory Committee was charged with developing methods to ensure that high quality services would be provided to the residents of the state. Some of the measures the Committee was asked to explore included: use of outcome data, practice guidelines, utilization review criteria, quality thresholds to use in selecting authorized health plans, professional liability reform, and the state's role in promoting health research. The committee was also asked to recommend mechanisms to monitor and enforce quality standards, including mechanisms to track the quality of health services provided to specific subpopulations.

Guiding Principles:

As the Quality Controls Committee evaluated different methods to ensure quality care, several policy principles emerged. These principles helped guide the Committee's recommendations:

1. Monitoring and ensuring quality care is critical in an era of cost containment.

2. Quality care must be assured throughout every part of the health system.

3. The state's system of quality assurance must provide for ongoing quality improvement and not only retrospective reporting mechanisms.

4. Quality assurance systems must assure that all health providers and community institutions work together in a public-private partnership aimed at improving the health status of the people in the community.

5. The state should ensure the provision of appropriate and needed health services in a cost effective manner.

6. The practice of medicine is an evolving science. The system must ensure that practitioners have the flexibility to change their practice of medicine as medical knowledge evolves.

7. Standards and methods to measure and ensure quality care are in their developmental stages. The State should establish a mechanism for ongoing review of quality standards.

8. Health providers, as well as researchers, consumers, payers/employers, insurance carriers/health maintenance organizations, and policy makers should be involved in the establishment of quality standards.

9. To the maximum extent possible, the State should build on and utilize existing quality measures, and not reinvent the wheel.

10. Sufficient resources must be devoted to assure high quality health services.

11. The system should analyze the quality of care provided to subpopulations (such as low income, people of color, people with disabilities) to ensure that the access and quality provided to at risk populations is not masked by the care received by the rest of the population.

Summary of Quality Controls Committee Recommendations:

The Report is broken down into the following subject areas: practice guidelines, report cards, quality thresholds, professional liability reform, outcomes research, and practice variations.

A. Quality Improvement Commission

The Committee recommended the establishment of a permanent independent Quality Improvement Commission, similar to the Medical Database Commission, with oversight and rule making authorities. The Quality Improvement Commission will have the responsibility of assuring quality through every part of the health system and by all health providers, including private health providers, publicly funded agencies, health plans and insurance carriers, etc. The Commission must be ongoing, with the responsibility of monitoring the effectiveness of different quality measurements, and how well the standards help improve health status.

In addition, to the state Quality Improvement Committee, the state should establish regional Quality Improvement Committees with the responsibility of ensuring the quality of care provided at the local level, as well as assessing community health priorities and how well different health providers meet the community health needs. These responsibilities could either be carried out by a separate regional Quality Improvement Committee or a Community Health District.

B. Practice Guidelines

The Committee recommended that the state help promote the use of practice guidelines by health care practitioners in North Carolina. Practice guidelines should be used to help maintain and improve quality of care, and should not be used to establish minimum standards which could decrease the quality of care provided. The state should establish a Practice Guidelines Committee to help establish the appropriate national guidelines to be used in the state. The Committee would initially establish a set of 20-25 priority areas for the establishment of guidelines. The guidelines would be established on the basis that

they are: high cost or high volume; serving a public health function; subject to great variations in treatment by different practitioners; or common in high risk populations. The guidelines should be periodically reviewed, and new guidelines should be established as appropriate. Practitioners should be taught and encouraged to use appropriate guidelines.

C. Report Cards

The state should establish multiple report cards: one for consumers and another for purchasers (e.g., employers). The Health Planning Commission or its designee would determine the content areas, including but not limited to: preventive services, prenatal care, public health measures, acute and chronic disease, mental health, functional status, access and satisfaction, health improvement programs, cost information, grievance information, enrollment and disenrollment information, and provider satisfaction data. Ideally, the report card should contain process as well as outcome variables that are severity adjusted. The items on the report card should be changed periodically, to ensure that plans focus on ensuring quality in the whole system, rather than focusing quality improvement efforts on report card items.

D. Quality Thresholds:

The Committee discussed the need to establish minimum quality thresholds which all health insurance carriers and health plans would be required to meet. Minimum quality thresholds would assure the adequacy of care provided in all plans. These standards are already needed, but may become even more necessary as the concern over rising health care costs has the potential of leading some plans to deny necessary services rather than eliminate waste.

The standards would apply to all health plans regulated in the state (including traditional major medical indemnity policies, HMOs, POS, PPOs, etc.), and eventually should cover ERISA plans. The standards would include structural, process, and outcomes requirements. The structural elements would include, but not be limited to: financial solvency, ability to provide a full array of services, and minimum provider:patient ratios. The process standards would cover: continuous quality improvement, expertise in the use of high technology and expensive procedures, communications with members, grievance procedures, continuity of care when patients change providers, credentialing requirements, provider compensation disclosure provisions, reporting requirements for provider disenrollment for cause, publicly available utilization review criteria and practice guidelines, enrollment and disenrollment provisions, patient confidentiality protections, informed consent, ombudsman provisions, billing protections for patients, and marketing rules. Outcome measures would look at health status information and outcomes measures (such as those included in the Healthy Carolinians 2000 or HEDIS reports), as well as an assessment of how well plans address community health needs.

E. Public Health Quality Assurance System

Most of the measures proposed by the Committee deal with the quality of clinical services provided by private or public providers. Similar protections are needed to ensure the quality of population based public health services aimed at improving community health status. The Quality Controls Advisory Committee recommended that the Quality Improvement Commission be given the responsibility to design a public health quality assurance process, using as a model, the Report of the Accountability Task Force of the Department of Environment, Health and Natural Resources.

The Public Health Accountability Report recommended a three-tiered accountability system to ensure the quality of public health services: 1) Level 1 is a "Community Wellness Index"--a measure of fourteen indicators of health status in each community; 2) Level 2 adds process measures to outcome measures, and attempts to measure how well the community and local health department are addressing the public health needs in a community; and 3) Level 3 is a continuation and coordination of current program specific assessments designed to assure compliance with state and federal regulations. Corrective action plans and follow-up monitoring would then be developed to ensure that problems identified are addressed.

F. Professional Liability Reform:

In developing their recommendations, the Quality Controls Advisory Committee considered the potential impact on quality and access to the courts for people who have been injured due to negligence. Most of the Committee's recommendations are intended to help lower the costs involved in the malpractice system--rather than eliminate the malpractice system altogether. The hope is that with lower costs, and reduced fear of malpractice suits, providers will be less likely to engage in defensive medicine. The savings generated from lower malpractice costs and the decreased defensive medicine can be funneled back into the system to provide greater access to the uninsured and better quality care:

The Committee's recommendations include:

1. Malpractice suits should be screened by a qualified expert prior to filing.

2. Qualifications of expert witnesses - expert witnesses should be board certified in the same or similar specialty, and should have prior experience treating similar patients.

3. Alternative Dispute Resolution - all cases should be required to first go through some form of ADR prior to having a trial in court.

4. Caps on Attorneys Fees - the State should establish a sliding scale cap on attorneys fees based on the amount of the award.

5. Subrogation - all regulated insurance carriers and HMOs should have the right to seek subrogation against other parties when found liable for the payment of the costs of health services.

6. Pain and Suffering - the State should establish a recommended schedule of awards to give juries for physical injuries, including pain and suffering.

7. Learning from Past Mistakes - the State should establish a mechanism to analyze and provide practitioners information about successful malpractice suits.

8. Protections from Incompetent Practitioners - the State should establish better mechanisms to ensure that the public is protected from incompetent practitioners.

9. Public access to malpractice cases - the public should have access to know the outcomes of successful malpractice suits decided in a court proceeding.

G. Outcomes Research

The Committee recognized the importance of outcomes research in developing appropriate standards of care. Outcomes research should be used in developing practice guidelines and in determining the benefits to be included in a state guaranteed benefit package. The state has a role to play in assuring that the outcome measures needed for report cards is being collected, as well as in assessing the quality of services provided by publicly funded health agencies. However, the Committee was reluctant to recommend that the state had a major role to play in the development or funding of clinical double-blind trials research.

H. Practice Variations

Similar to outcomes research, the Committee recognized the importance of understanding more about practice variations in this state. However, they were again, reluctant to recommend that the state put significant resources into funding studies in this area.

K. ELIGIBILITY AND ENROLLMENT - Reporting Date: December, 1994

The Eligibility and Enrollment Advisory Committee was charged with making recommendations to the North Carolina Health Planning Commission about who to include in the new plan, for example, whether Medicaid, Medicare, CHAMPUS, federal and state employees should be included or whether certain sized groups should be permitted to opt out of the state sponsored plan. It was also charged with recommending an enrollment system for the new plan.

The Eligibility and Enrollment Advisory Committee explored the various population groups in North Carolina and secured actuarial projections of the cost of covering those groups with the basic, intermediate and expansive benefit packages determined by the Benefits Advisory Committee. Those estimates provided gross indications of the cost for each population group but did not address the impact of the new health plan either on individuals or employers. In its September 1994 interim report, the Committee made initial recommendations to the North Carolina Health Planning Commission for population groups to be included in the financial modeling for the new health plan.

In its interim report, the Committee also indicated strong support of ensuring that all North Carolinians have access to health care and of developing some systematic way to prioritize or target expansion of access to health care incrementally. The Committee requested that the North Carolina Health Planning Commission assess how Medicaid might be expanded to cover more low income individuals and explore the expansion of the public health providers, such as rural, community and migrant health centers, local health departments, and area mental health programs, to reach more uninsured individuals including an assessment of financial impact on both state and local governments.

The financial models revealed that to move to universal coverage by 1998 will require new state revenue ranging from $1 billion to $2.3 billion depending on how the requirements are established. These sums led the Financing Committee to come to the conclusion that none of the vehicles leading to universal coverage present attainable financing options. Consequently, its recommendations are in support of mechanisms that would provide health insurance coverage to more of the uninsured either directly or indirectly. Medicaid expansion is a crucial component of the Financing recommendations.

When the Financing Advisory Committee reported that its recommendations are based on Medicaid expansion for which eligibility and enrollment requirements are already established, the Committee did not pursue establishing specific requirements for the different financing and delivery system combinations. However, this final report includes an overview of the critical eligibility and enrollment issues that will have to be addressed in future discussions of universal health care coverage.

The Eligibility and Enrollment Advisory Committee developed recommendations which will increase access to health care using these key concepts. The Committee believes the state should avoid wholesale reordering of health care system and pursue options that would extend health care coverage to more uninsured individuals. A first step would be to expand Medicaid to cover more low income uninsured individuals. Concurrent with Medicaid expansion, it is imperative to address the needs of low income individuals who are ineligible for Medicaid but cannot afford private insurance.

The Eligibility and Enrollment Advisory Committee offers the following recommendations leading to increased health care coverage for many low income North Carolinians.

1. Establish priorities for expanding Medicaid eligibility.

The following reflects the Committee's ranking of the groups in priority order for expanding eligibility and the recommended maximum eligibility income level as a percentage of federal poverty.

Group	Percentage of poverty
Children from birth to age 19	200%
Pregnant Women	200%
Elderly	200%
Disabled	200%

The Committee supports Medicaid expansion with an income level of 200% of the federal poverty level as the eventual goal for eligibility. However, the Committee also recognizes that a phase-in will be required with lower initial income limits, in coordination with other changes and modifications being recommended by the Commission. Establishing the schedule for phase-in has been deferred to the Health Planning Commission. The Committee's proposed priority list for phasing in Medicaid coverage is as follows:

- infants under age one at 200% federal poverty level (FPL)
- elderly and disabled at 75% of FPL
- children age 1 through 5 at 185% FPL
- children age 1 through 5 at 200% FPL
- pregnant women at 200% FPL
- children age 6 through 18 at 133% FPL
- children age 6 through 18 at 185% FPL
- children age 6 through 18 at 200% FPL
- pregnant women post partum at 185% FPL
- pregnant women post partum at 200% FPL
- other elderly and disabled at 200% FPL

2. **Pursue outreach for Medicaid applications in nontraditional settings**

   The Committee defers to the Division of Medical Assistance to identify such settings with the recommendation that locations such as schools, recreation departments and provider offices be considered.

3. **Encourage implementation of the recommendations from the Rural and Urban Medically Underserved Areas Advisory Committee designed to establish or expand rural and community health centers**

   Specifically, the Committee supports these efforts because community health centers provide a crucial link to address the needs of low income individuals who are ineligible for Medicaid but cannot afford private insurance.

4. **Encourage approval of the recommendations of the Primary Care Advisory Committee which ensure that primary care providers are available in medically underserved areas.**

   A sufficient supply of primary caregivers is crucial to insuring accessibility and availability of needed health care.

5. **Encourage development of support services.**

   Recognizing that expansion of the safety net for health care is a priority, the Committee encourages the development of supportive services emphasizing the need for transportation services and child care that allow a person to receive needed medical care.

6. **Insurance Reform**

   The Committee supports measures proposed by the Insurance Reform Advisory Committee that open the market to allow some individuals currently priced out of the market to purchase coverage. Those measures could include an adjusting community rating with variations for age, geography and family size, restrict preexisting condition limitations to an appropriate length, guaranteeing issuance and renewability of all products, and portability provisions that apply regardless of source of previous coverage (if relatively comparable coverage).

7. **Ensure that public debate continues on whether every North Carolina resident has a right to health care or health care insurance particularly addressing those uninsured who are not Medicaid eligible.**

   The Committee defers to the Health Planning Commission on how to accomplish this important task.

L. INSURANCE REFORM - Reporting Date: December, 1994

The Insurance Reform Advisory Committee based its recommendations on the following Principles:

1. The private, employer-based health benefits marketplace is the foundation upon which insurance reforms will be based for the foreseeable future.

2. The role of government should be to facilitate and encourage the private sector's efforts to make health benefits coverage more accessible, affordable, and meaningful.

3. Reform can best be accomplished on an incremental, step-by-step basis, in which initial improvements are tried, tested, and their results measured before additional reforms are initiated.

4. Under existing federal law, self-funded health benefits plans are exempt from state regulation. This represents about 65% of the insurance market in North Carolina. In the past, most self-funded plans were utilized by larger companies which had significant financial resources and offered generous benefits plans. Today, an increasing number of smaller companies are seeking to "self-insure." North Carolina should ensure that companies that seek to self-fund their health benefits plans have adequate financial resources to meet their commitments to their employees.

5. North Carolina has made significant improvements in recent years to the small group market for health insurance. These reforms have made it easier for small businesses to obtain insurance. Gaps remain in these reforms, however, that can be remedied to make our small group reforms work even more effectively.

6. The most difficult market to reform is the individual market—persons seeking to obtain insurance without being a member of any group. Individuals still face many obstacles to coverage. In a voluntary market without universal coverage, however, eliminating all the obstacles is not workable, as it would potentially lead to adverse selection and other abuses of the marketplace. Nonetheless, some improvements are appropriate to make health insurance easier for individuals to obtain.

Recommendations:

1. All health benefits plans, for both individuals and groups, should be "portable."

2. Preexisting condition exclusions should be limited to twelve months' duration for all individual health benefits plans, and to six months' duration for all group plans.

3. All group health benefits plans should be "guaranteed issue."

4. All group health benefits plans should be "guaranteed renewable."

5. Gender should be eliminated as a category for consideration in determining the adjusted community rating of all small group health benefits plans.

6. All health benefits plans should provide mandatory first-dollar, no-deductible coverage for reimbursement of the reasonable and customary cost of immunizations provided by physicians participating in the federal Vaccines for Children program.

7. Stop/loss provisions in health benefits plans should be limited.

8. Subrogation, in an amount up to 1/3 of the total recovery, should be allowed for all health benefits plans.

9. Third party administrators, insurers, or any payers should be prohibited from unilaterally demanding discounts and from withholding payment of provider charges when that provider has already rendered services, and the charges for those services have not been negotiated in advance.

10. The Department of Insurance uniform claims initiative related to claims simplification and supporting documentation should be encouraged and enacted as soon as possible.

11. North Carolina should fully study and implement, if feasible, a requirement that employers of groups of over 25 employees offer, but not pay for, health insurance for their employees. The state should also study whether employers of 25 or fewer employees may voluntarily offer such health insurance to their employees.

12. The small business purchasing alliances are a positive approach to making insurance available to small group purchasers. They should be strongly marketed to ensure that potential purchasers are aware of their benefits.

13. The General Assembly should enact meaningful health care cost containment measures if it wishes to effectively reform health insurance to make it more accessible and affordable for North Carolinians.

M. FINANCING - Reporting Date: December, 1994

The Financing Advisory Committee of the North Carolina Health Planning Commission was charged with making recommendations on how to pay for a new health plan which would provide all North Carolina residents with health care that is accessible and affordable. The Committee examined the impact of different financing options (tax financed single payer, employer mandate and individual mandate) on different groups, including individuals, families, large and small businesses and federal, state and local governments. A broad agreement emerged within the Committee that none of the vehicles studied leading to universal coverage present attainable financing options. Consequently, the Committee's recommendations relate to a proposal referred to as "Immediate Measures Leading to Reform."

These immediate financing measures would lead to universal availability for low income uninsured individuals with incomes at or below 200 percent of federal poverty guidelines and begin a systematic progression towards the goal of universal accessibility for all North Carolina residents. First steps in that progression build on several key components: Medicaid expansion; insurance reform; encouragement of employer-based coverage; and consolidation of purchasing power. This progressive financing would support other recommendations of the Health Planning Commission or the Financing Committee such as incentives for primary care providers in underserved areas, encouraging "home grown" North Carolina networks and periodic review of progress.

1. Medicaid expansion -- The Committee recommends the following Medicaid expansions to extend health care coverage to more of the uninsured.

a) Phase-in expansion of Medicaid for pregnant women, children under 19, aged and disabled individuals eventually reaching 200 percent of federal poverty.

b) Explore the possibility of and ways to finance the non-federal share of a Medicaid waiver that would allow NC to extend coverage to uninsured persons aged 19 to 64 not otherwise eligible for Medicaid with incomes up to 200% of federal poverty.

2. Insurance Reform -- The Committee supports measures proposed by the Insurance Reform Advisory Committee that open the market to allow some individuals currently priced out of the market to purchase coverage.

3. Encouragement of Employer-Based Coverage -- The Committee believes that North Carolina should encourage the continuation and growth of employer-based health insurance coverage, perhaps, through the development of incentives. One incentive may be participation in purchasing pool as described in the next section.

4. Consolidated Purchasing Power for Health Care Coverage -- Efforts should be initiated to allow the State Employees Health Plan, small employer health care purchasing

alliance members and possibly Medicaid to consolidate purchasing power in some appropriate manner that would not affect the organizational integrity of participating members.

5. Incentives for Primary Care Providers in Underserved Areas -- Access to primary care is problematic in many parts of North Carolina. The Committee supports recommendations from the Rural and Urban Medically Underserved Areas and Primary Care Committees to ensure that primary care services are available.

6. Encourage "Home Grown" Networks -- North Carolina must address problems other states have experienced with managed care businesses which enter a market and leave when it does not prove as profitable they expected. Encouragement and support of locally developed provider-based networks should be explored as one mechanism to avoid potential problems.

7. Periodic Review of Plan -- Whatever plan the Commission approves should include check points to allow review and revision as needed. Perhaps the Commission should consider establishing phased-in target coverage levels and the date by which each is to be met.

The Committee, in addition to the immediate measures, has included in its final report a full discussion of several topics that it explored so that the Health Planning Commission has the benefit of that information as it forges a comprehensive health plan for North Carolina.

Appendix F

Chart on Prior Health Reform Efforts

SELECTED HIGHLIGHTS: HISTORY OF HEALTH REFORM IN NORTH CAROLINA

Year	State Government Action	Private Sector
1930s		Private insurance system started in NC with hospital care association and hospital savings association, both precursors to Blue Cross and Blue Shield of NC.
1940	UNC Bd. of Governors creates School of Public Health	
1941-1945		NC - Highest Proportion of Draftees Rejected due to Medical Conditions; Bowman Gray starts 4 years medical school
1944	Gov. Broughton started program to enlarge medical schools and strengthen NC hospitals	
1947-1952	Expanded UNC Medical School to four year program; built UNC hospitals	
1970	NC implements Medicaid program	
1970s		First PA program in country at Duke
1973	NC Office of Rural Health created	
1974	AHEC created	
1975	State health planning; Certificate of Need created; ECU School of Medicine created	
1981	Medical Cost Containment Study Commission authorized	Foundation for Alternative Health Plans organized to stimulate the development of HMOs in NC
1983	NC Institute of Medicine chartered by General Assembly	
1984	Medical Cost Containment Legislative Study Commission recommended creation of Medical Database Commission which began in 1985	First true HMO, Kaiser-Permanente, begins operation in NC

SELECTED HIGHLIGHTS: HISTORY OF HEALTH REFORM IN NORTH CAROLINA

Year	State Government Action	Private Sector
1985-1987	Indigent Health Care Legislative Study Commission • expands Medicaid to cover pregnant women, children<2 w/incomes up to FPG • expands Medicaid to cover 19-21 yr olds	
1987	Proposal for high-risk individual coverage program by NC Dept. of Insurance proposed; fails by narrow margin	
1987	Certificate of Need laws weakened	
1988	Hospital Garnishment law passed	
1987-1989	Indigent Health Care Legislative Study Commission • expands Medicaid to cover pregnant women/infants up to 150% FPG • expands Medicaid to cover children <6 with incomes up to 100% FPG • Insurance protections for large groups >50 employees	In 1988, North Carolina has 880,000 uninsured persons
1987-1988	Small Employers' Health Insurance Trust Legislative Study Commission. • Produced "Small Employers Purchasing Guide"	
1989		NC Inst. of Medicine creates strategic plan to assist Medically Indigent of NC. Calls for universal coverage.
1989	High risk pool proposal fails again	Blue Cross Blue Shield establishes Access program (insurance of last resort for high risk)

SELECTED HIGHLIGHTS: HISTORY OF HEALTH REFORM IN NORTH CAROLINA

Year	State Government Action	Private Sector
1990	NC Infant Mortality reduction campaign initiated, includes: • expand Medicaid to cover pregnant women/infants < 185% FPG • Maternity care coordination; case management children <5 started • ROCI program expanded • Recruit health providers to medically underserved areas	NC learns it has worst infant mortality rate in country (1988 estimates)
1991	• Public Health Study Commission authorized • NC Legislative Study Commission on Access to health insurance authorized • Enacted small group reform legislation, making it easier for small employer groups to purchase insurance	Health Access Forum convened by NC Institute of Medicine, commonly called "Friday" Commission (after William Friday, chair)
1991	Second year infant mortality reduction campaign, includes: • expansion of ROCI/WIC programs • expansion of family planning • ECU establishes nurse midwifery program • Study of extent of women w/o maternity care coverage	
1992	Third year infant mortality reduction campaign, includes: • child vaccines for community, rural health centers, private providers • adolescent health care programs started • expansion of Medicaid healthy children healthy teens outreach	Total number of uninsured estimated at close 1 million.
1992	Health Insurance Access Study Commission holds meetings across state; develops tax supported managed competition bill	Friday Commission finishes report, develops tax supported, managed competition proposal; NC has 8 approved HMOs operating in state

SELECTED HIGHLIGHTS: HISTORY OF HEALTH REFORM IN NORTH CAROLINA

Year	State Government Action	Private Sector
1993	Access to Health Insurance Commission reports to GA which includes a managed competition bill (not passed). Other recommendations passed by GA, include: • Primary health care initiative, to attract more primary care providers to medically underserved areas • Certificate of Need laws strengthened to become one of tightest in country • Self referrals prohibited bill • Caring Program for Children expanded	
1993	Fourth year infant mortality initiative, includes: • Family planning expansion • Adolescent health program expansion • Replaced lost federal MCH funds	
1993	HB 729 passes. Bill includes: • Creation of NC Health Planning Commission, chaired by Governor • Directs Governor to create Dept. of Health • Directs Dept. of Health to create Community Health Districts • Goals to produce 60% primary care graduates in public medical schools; 50% for private medical schools • Small group purchasing alliances created (to group together small employers with 50 or fewer employees) • Hospital Cooperation act passed, allows hospitals to cooperate in joint ventures with other providers if in public interest	Carolinas Medical Center in Charlotte, hospitals in Winston-Salem, Duke and East Carolina Schools of Medicine begin development of networks of affiliated organizations

SELECTED HIGHLIGHTS: HISTORY OF HEALTH REFORM IN NORTH CAROLINA

Year	State Government Action	Private Sector
1994	NC Health Planning Commission staffed; meets monthly. • 13 Advisory Committees formed; make recommendations to Commission beginning in September, ending in December 1994. • Principles passed, includes: universal coverage, cost containment, comprehensive benefits, emphasis on health status, affordability, high quality, etc.	In 1994, there were 14 HMOs licensed in North Carolina, with an additional five license applications pending. Between 30 to 60 PPO's have requested applications.
1994	Health legislation passed in General Assembly, includes: • Medicaid expansion to cover all poor children under age 19 (< 100% FPG) • Medicaid will cover all SSI eligibles beginning January 1, 1995 • Further expansion of primary care initiative	
1995	NC Health Planning Commission to introduce legislation into 1995 General Assembly.	First small business alliance expected to offer insurance products in Western NC

STATEMENT OF COST
3,000 copies of this publication were published by the North Carolina Health Planning Commission at an estimated cost of $10,735.00 or $3.58 per copy.